Neurology, Sleep & Pulmonary Specialists

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RELEASE OF PROTECTED HEALTH INFORMATION

To release the personal health information of: **PATIENT'S NAME** _____

Date of Birth _____ OR Last Four of Social _____

Address _____ Telephone _____

AUTHORIZE FROM:	RELEASE TO:
Address City/State/Zip	Address City/State/Zip
Phone/Fax	Phone/Fax

Release the following information:

_____ Entire Record OR Specific Dates of Service _____

_____ Verbal Information - To _____

_____ Partial Record to include: ___Discharge Summary ___ Consult ____ Operative ___ Labs

___ Office Notes ___ H&P ___ Treatment ___ Radiology ___ OTHER _____

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials:_____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented:
Initials:_____ drug and/or alcohol diagnosis, treatment, test results and reports and referral information.
Initials:_____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or
Initials:_____ venereal disease information.

This authorization will remain in effect:
_____ From the date this authorization was signed until _____ (not over 1 year)
_____ Until the Releasing Entity fulfills the request or you have revoked this authorization

The information released according to your direction may be subject to re-disclosure by the recipient of the information and may no longer be protected by federal or state law. I may refuse to sign this authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this authorization unless my treatment is research-related or I am to receive healthcare solely for the purpose of creating protected health information for disclosure of the Recipient identified in this authorization. I have the right to revoke this authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Releasing Entity in reliance on this authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorization above Releasing Entity to use or disclosure my health information in the manner described above.

_____ _____

Signature of Patient or Legal Representative **Date**

If signed by Legal Representative, state Relationship to Patient _____

Revised 03/22/19