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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Address (Line 1): _____

Date of Birth:_____ Address (Line 2): _____

Phone #:_____ City/State/Zip: _____

The above listed patient authorizes Neurological Institute of Northern Virginia PC to disclose medical records to the following:

Name:_____

Address:_____

City/State/Zip:_____

Phone Number:_____Fax Number: _____

EMAIL: _____

Fees: $10 Processing fee, plus $0.50/page for the first 50 pages, and $0.25/page after 50th page

Dates and type of information to disclose:
- ⎦ 2 years prior from last date seen
- ⎦ Dates Other:
- ⎦ Specific Information Requested:_____
  _____

The purpose of disclosure is:
- ⎦ Change of insurance or physician
- ⎦ Continuation of care (e.g., VA Med Ctr)
- ⎦ Referral
- ⎦ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human acquired immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____
Printed name of Authorized Representative Relationship / Capacity to patient