RELEASE OF INFORMATION

Authorization for Use or Disclosure of Health Information

Patient Name____

Date of Birth________________________

Patient Identification (SSN or chart number_______________________________________

By marking the boxes below, I hereby authorize the use and/or disclosure of the following individually identifiable health information:

Dates of Service____

Consultation & Office Notes_____ Electroencephalogram EEG Report_____

History & Physical_____ Labs/ Xray/ MRI/ Other test Report_____

Discharge Summary_____ All Medical Records_____

Other (must specify

____

(The above information will be called "Authorized Information" throughout the rest of this form)

Authorized Information requested from: Release Authorized Information to:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

The Authorized Information will be used and/or disclosed for the following purposes:

Personal Use Judicial Proceedings Continuation of Medical Care

Other (must specify)

____

I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Carolina Child Neurology, PLLC in writing. However if I choose to do so, I understand that my revocation will not affect any actions taken by Carolina Child Neurology, PLLC before receiving revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility of benefits.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _______________________. If fail to specify an expiration date, event, or condition, this authorization will expire in 12 months.

Signature of Patient or Patient Representative_____________________________________

Date___________________________

Witness Signature____