NeuroResources
Neuropsychological Services

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes _____to use or disclose copies of certain medical record
(Name of Facility)
information as specified below:

PATIENT NAME _____ MEDICAL RECORD NUMBER_____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

ADDRESS: _____ PHONE# _____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE:

_____HISTORY AND PHYSICAL
_____NEUROIMAGING REPORTS
_____PROGRESS NOTES
_____DISCHARGE SUMMARY
_____OPERATIVE REPORTS
_____X-RAY REPORTS
_____ NEUROPSYCH TESTING (Raw Data)
_____ NEUROPSYCH TESTING (Report)
_____OTHER – Specify _____

INFORMATION IS TO BE RELEASED TO:

Name _____

Address _____

_____

City _____ State _____ Zip _____

Phone _____ Fax _____

PATIENT TYPE: _____INPATIENT _____OUTPATIENT DATES OF TREATMENT: _____

PURPOSE OR NEED FOR THIS DISCLOSURE OF INFORMATION: _____

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used, or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic expiration date will be six (6) months from the date of signature or upon occurrence of the following event:_____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). (SEE 63 O.S. § 1-502.2).

NOTICE TO RECIPIENT OF COPIES OF ALCOHOL AND DRUG ABUSE MEDICAL RECORDS:

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Chap. 1, Part 2, Subpart CD § 2.32). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Chap. 1, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 for the first offense and $5,000 in the case of a subsequent offense.

THIS DOCUMENT SPECIFICALLY AUTHORIZES THE RELEASE OF PSYCHIATRIC INFORMATION. IF PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED TO THE PATIENT, PHYSICIAN CONSENT FOR SUCH RELEASE MUST BE OBTAINED.

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

_____ _____
DATE PATIENT SIGNATURE / LEGAL REPRESENTATIVE

COMPLETE THE FOLLOWING IF PATIENT IS DECEASED, A MINOR, OR MENTALLY INCAPACITATED. AUTHORIZATION MAY BE GIVEN BY A LEGALLY AUTHORIZED REPRESENTATIVE, IDENTIFIED BELOW:

_____ _____
REASON PATIENT UNABLE TO SIGN SIGNATURE

_____ _____
DATE RELATIONSHIP