Neurology Clinic, PC
8000 Centerview Parkway, Suite 500
Cordova, TN 38018
901-747-1111, 901-747-1137 (eFax)

HIPAA Release of Information
AUTHORIZATION FORM

I, ____ authorize Neurology Clinic, PC to:
(Print Patient's Name)

☐ Obtain/request copies of my health information from:

____
(Name and Address) –Specify: Hospital, Doctor, etc.

This authorization for release of information covers the:

☐ Complete medical record of treatment including office notes, laboratory reports, radiology reports, physical/occupational/speech therapy notes, and any other ancillary/Doctor/Nurse notes.

☐ Description of specific records to be released: ________________________________

I authorize the release of my complete health record **with the exception** of the following information:

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify): ____________________________

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that this authorization cannot be retroactively revoked for information that has already been sent.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. However, if I need records sent or received at a later date I understand this form must be signed by me at that time.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

I understand that even if I do not withdraw this authorization, it will expire **one (1) year** from the date below.

____	____________________________
Signature of Patient/Parent/Legal Guardian/Representative	Patient's Date of Birth
____	____________________________
Printed name of Parent/Legal Guardian/Representative	Relationship to patient

____
Date