NEUROLOGIQUE FOUNDATION, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

This authorization is for the release of medical information.

PATIENT'S NAME _____
Last First M.I.

ADDRESS _____

BIRTHDATE _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month Day Year

SOCIAL SECURITY NO. _____

AUTHORIZATION:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE FROM LIABILITY:

I FURTHER UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION COULD POTENTIALLY BE RE-DISCLOSED AND MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS. THEREFORE, I RELEASE **NEUROLOGIQUE FOUNDATION, INC.** FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED BELOW.

ORGANIZATION RECEIVING INFORMATION:

(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)

STREET ADDRESS

CITY STATE ZIP CODE

INFORMATION TO BE DISCLOSED:

☐ All records **OR**

☐ Demographic Information ☐ Lab Reports ☐ Diagnostic Test Reports ☐ Counseling Notes ☐ Consultant Reports

☐ Other (please specify):_____

PURPOSE OF DISCLOSURE:

☐ Second Opinion ☐ Continuing Medical Treatment ☐ Patient Request

☐ Marketing Promotion: I have been informed that Neurologique Foundation, Inc. __is __ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

☐ Other (please specify): _____

I understand that this authorization will expire one (1) year from the date of signature below.

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SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

IN ADDITION TO ANY RECORDS CHECKED ABOVE, THE FOLLOWING INITIALED RECORDS MAY BE RELEASED:

_____ HIV/AIDS related information and/or records

_____ Mental Health information and/or records

_____ Sexually transmitted diseases

_____ Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE**: _____
Patient or legal representative

RIGHT TO REVOKE AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING TO THE PRACTICE, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

Authorization Copy Received: ☐ Yes ☐ No

SIGNATURE:

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date:_____

Patient Signature:_____

Parent, Guardian or Legal Representative Signature:_____

Printed Name of Parent, Guardian or Legal Representative:_____

Relationship to Patient:_____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate, etc.): _____

Witness Signature:_____