Authorization for Release of Information

Patient Name: **SSN:**

☐ **TO Neurology Specialists, PA:**

I authorize ____ at
(Name of physician or authorized facility)

____
(Street address)

____
(Telephone and Fax numbers)

to release to Neurology Specialists, PA my medical, psychiatric, HIV, and AIDS-related testing or results and / or substance use information from my medical records.

☐ **FROM Neurology Specialists, PA:**

I authorize Neurology Specialists, PA to release my medical, psychiatric, HIV, and AIDS-related testing or results and / or substance use information from my medical records to

____ at
(Name of physician or authorized facility)

____
(Street address)

____
(Telephone and Fax numbers)

The requested information may be delivered to *Neurology Specialists, PA* by mail, facsimile or any other means authorized by me or permitted by law. I understand that I may revoke this consent at any time before the information has been released. This authorization expires one (1) year from the date below.

Any alcohol or substance use information, HIV or AIDS-related information released is protected by Federal Regulations and may not be re-disclosed without an explicit written consent of the undersigned.

Patient Signature: ____ OR

Signature of Legal representative: ______________________________
(Copy of Power of Attorney for Health Care must be attached)

Date: ____

NEUROLOGY
SPECIALISTS