NEUROLOGY ASSOCIATES OF NORWALK

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AUTHORIZATION FOR ACCESS/RELEASE OF INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

ADDRESS _____

I HEREBY AUTHORIZE NEUROLOGY ASSOCIATES TO RELEASE INFORMATION TO:

NAME _____ COMPANY/PRACTICE _____

ADDRESS _____

PHONE _____ FAX _____

INFORMATION TO BE RELEASED OR OBTAINED (*CHOOSE ONLY ONE OPTION*):

☐ copy of items listed with dates of service: _____

☐ copy of most recent visits, testing & original consult

☐ copy of all medical records for the past _____ years

☐ copy of all medical records

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1. I understand this authorization will expire one year after I've signed the form or as specified.
2. I understand that I may revoke this authorization in writing at any time, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
3. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand I am not required to sign this form in order to receive treatment.
5. **I understand that there is fee for copies of medical records which is $0.65 per page plus postage**. As a courtesy, there is no charge if you are requesting only your most recent visits, testing & original consult to be faxed directly to another treating physician. Please be sure you supply a fax number and that it is accurate for any records going to another physician. By signing this request I agree to pay this fee prior to receiving my records.
   Please do not request your records if you are not willing to pay the fee involved.
6. I understand that information to be released or obtained may include mental health, substance abuse or HIV/AIDS related information.
7. I understand that a minimum of 3 days and maximum of 30 days are required for all requests.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON _____ DATE _____

IF SIGNED BY AN AUTHORIZED PERSON, A COPY OF LEGAL POWER OF ATTORNEY MUST ACCOMPANY THIS REQUEST