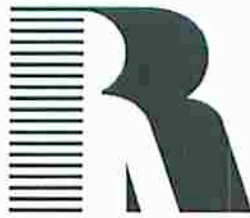

RALEIGH NEUROLOGY ASSOCIATES, P. A.

Authorization to Release Health Information

Name of Patient: ______________________ Date of Birth: ______________

Raleigh Neurology Associates, P.A. is authorized to release protected health information about the above named patient to the persons named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Individuals to Receive Information. Check and list name of each person that you approve to receive information.	**Description of information that may be released.** Check each that can be given to person on the left in the same section.
Patient/Guardian: ❑ Voice Mail ❑ Email	❑ Results of lab tests/radiology results ❑ Appointment Information/General Message ______________
❑ Spouse (list name) ______________	❑ Financial ❑ Health Information: ______________
❑ Parent (list name(s)) ______________	❑ Financial ❑ Health Information: ______________
❑ Child(ren)/Other (list name(s)) ______________	❑ Financial ❑ Health Information: ______________

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

______________________________ Date: ______________

Patient/Legal Guardian/POA (please attach documents)

Relationship to Patient: ______________________________

Revised September 2009

Staff Initials: ______________