RALEIGH NEUROLOGY ASSOCIATES, P.A.

RALEIGH NEUROLOGY IMAGING

1540 Sunday Drive, Raleigh, NC 27607 | P. 919-782-3456 | F. 919-783-1441 (Adults)
1520 Sunday Drive, Raleigh, NC 27607 | P. 919-782-3456 | F. 919-788-8986 (Pediatrics)
4111 Ben Franklin Rd. Durham, NC, 27704 | P. 919-719-8834 | F. 919-582-0528

Medical Records Release

Release of Information Direct Fax 919-325-4693

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____ SRS #_____

City, State, Zip _____Phone #_____

Information to be released from: _____
(FULL MAILING ADDRESS NEEDED, PHONE, & FAX NUMBER)

_____

Information to be sent to: _____
(FULL MAILING ADDRESS NEEDED, PHONE, & FAX NUMBER)

_____

Information to be released:

- ☐ **The most recent pertinent information** (office notes, labs, radiology reports, medication lists and special testing.)
- ☐ **Completion of Disability, DMV, and /or FMLA form(s).**

Treatment Dates: _____

☐ **Office Notes** ☐ **Lab Work** ☐ **X-Ray Reports** ☐ **Diagnostic Studies**
☐ **Specific health information:_____**

☐I Do ☐Do Not authorize release/request for information regarding drugs, alcohol, HIV, and/or mental health.

The information below is being disclosed for the following purpose:

☐ **Continued Care (Information being sent directly to another physician/healthcare facility)**
☐ **Personal** ☐ **Legal** ☐ **Insurance** ☐ **Other (please specify) _____**

This authorization shall be in effect until the information has been forwarded/obtained as requested unless specified - _____
(PLEASE SPECIFY A DATE AND/OR EVENT THIS RELEASE WILL EXPIRE)

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. ***I understand that information 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 revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the medical record department at RNA.

I agree to pay all charges for copies of medical records when they apply.

_____ _____

Signature of Patient or Authorized Personal Representative Date:
Relationship to Patient_____