RECORDS RELEASE AUTHORIZATION

TO: _____

_____

_____

I HEARBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
METROLINA NEUROLOGICAL ASSOCIATES, PA

Howard Mandell, M.D.
Benjamin T. Colston, PA
Poonam Poonam, M.D.

❑ 1665 Herlong Court , Suite B, Rock Hill, SC 29732 • Phone (803) 366-6135 Fax (803) 366-3439
❑ 127 Professional Park Drive, Rock Hill, SC 29732 • Phone (803) 366-6135 Fax (803)329-8645

Description of information to be released /used:
Date of Service: _____ Service Provided: _____ Describe in detail the level of information to be released
_____.

Permitted use of the described information or reason for the request:
_____.

This authorization shall be in force and effect until:
Date of Expiration _____ (or) description of an event that will cause this authorization to expire. The event may relate to the patient or the intended use or disclosure _____.

NAME_____

ADDRESS_____

_____

SSN: _____ DATE OF BIRTH _____

SIGNATURE _____ DATE_____

Rights of the Patient
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address on this authorization.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may not longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to the address on this authorization.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

_____

Signature of Patient Date

_____

Print or Type Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Authorization for Release of Protected Health Information
Metrolina Neurological Associates

Patient's complete name & current mailing address

Patient's Full Name _____ Patient's Date of Birth _____

Address _____ Patient's Social Security Number (last 4 digits) Optional _____

City, State, Zip Code _____ Patient's Telephone Number _____

I hereby authorize use or disclosure of protected health information about me as described below.

_____ is authorized to use or disclose information about me to:
Facility Name

Complete name & address of where records are to be sent →

Recipient Name:
Street Address:
City, State, Zip:
Phone/Fax Number:

Information for treatment period: From (date) _____ To (date) _____

Information to be released: ☐ All Records OR (Please check all that apply)

___ Office Notes/Physician Dictation
___ Laboratory Tests
___ Radiology Reports
___ Bill
___ Pathology Reports
___ EKG/Cardiovascular
___ Ultrasound Reports
___ Medication
___ Immunization Records
___ Physical Therapy Records
___ Other _____

For the purpose of: ___ Legal Investigation ___ Insurance ___ Disability Determination ___ Other _____
___ Transfer (There will be a charge billed to the patient for the transfer of medical records)
This facility would like to know the reason for your transfer _____

Sensitive Information: I understand that my record may include, and therefore be released, information relating to AIDS/ HIV, psychiatric/psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol, drug and/or sex abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and would then no longer be protected by federal privacy regulations.

Revocation: I understand that I have the right to revoke this authorization at any time in writing by notifying _____. However, the revocation will not apply to information already released based on this authorization.

Expiration: I understand that this authorization will expire upon the following date/event _____. However, if no date/event is specified, this authorization will expire in twelve months from the date signed.

Charges: Federal and state laws permit a fee to be charged for obtaining the requested information. This facility has contracted with SCANSTAT TECHNOLOGIES to process medical record requests. By signing below, you agree to pre-pay for the copies. Your copies will be sent after payment is received by SCANSTAT. Any questions regarding fees may be directed to 843-253-0127.

Services: I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

Signature required on all forms-Do not print →

_____ Signature of Patient or Legal Representative

_____ Date ← Date required on all forms

_____
Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)