RECORDS RELEASE (INCOMING) AUTHORIZATION

Name and address of Clinic/Physician sending records:

_____

_____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
METROLINA NEUROLOGICAL ASSOCIATES, PA
1665 Herlong Court
Suite B
Rock Hill, SC 29732
Phone - 803-366-6135 Fax – 803-366-6155

Howard Mandell, M.D. · H. Dean Reeves II, M.D. · David Buckland, D.O.
Poonam Poonam, M.D. · Benjamin Colston, PA-C

Description of information to be released/used:

Date of Service(s): _____

Type of Service(s) Provided: _____

Describe in detail the level of information to be released: _____

_____

Reason for the request: _____

This authorization shall be in force and in 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: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PATIENT RIGHTS:

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 no 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 Name of Patient of Personal Representative

_____

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