Authorization for Release of Protected Health Information Metrolina Neurological Associates

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Office Notes/Physician Dictation Pathology Reports Immunization Records Radiology Reports Ultrasound Reports Other Bill Medication 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 AIDS/ HIV, psychiatric/psychological assessment, behavioral and/or mental health services, sexually transmitted 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 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 contracted with SCANSTAT TECHNOLOGIES to process medical record requests. By signing below, you agree pay for the copies. Your copies will be se	Information for treatme	ent period: From (da	ite)	To (date)	·	
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Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)