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)