

**Neurosurgical Associates PC Authorization to Release Medical Information**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
SS or Health Record Number

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient DOB

\_\_\_\_\_ I authorize (practice/physician's name) to use or release/disclose my health information as described below.

Please identify the information to be released:

Please release my entire record

-OR-

Please release **only** the following information (check appropriate boxes and include other information where indicated):

Problem list

Medication list

List of allergies

Immunization records

Most recent history

Most recent discharge summary

Lab results (please describe the dates or types of lab tests you would like disclosed): \_\_\_\_\_

X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): \_\_\_\_\_

Consultation reports (please supply doctors' names): \_\_\_\_\_

Other (please describe): \_\_\_\_\_

The identified information will be used for the following purpose:

My personal records

Sharing with other health care providers as needed

Completion of insurance forms / disability forms / FMLA

Other (please describe): \_\_\_\_\_

**Please initial each item below to indicate your understanding.**

\_\_\_\_\_ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

\_\_\_\_\_ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

\_\_\_\_\_ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

\_\_\_\_\_ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

This authorization will expire on (insert date or event): \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (or Signature of Person Completing Form if Not Patient\*)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\*Relationship to patient:  Parent  Legal Guardian  Other: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



Charles Clark III M.D. | Carter Harsh M.D. | Robert Poczatek M.D. | Thomas A.S. Wilson Jr. M.D.

## Patient Medical Record Request Informative

**Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

This letter is in response to the request for medical records. In order for us to process your request, please sign and return the attached authorization form. We have also included a copy of our Notice of Privacy Practices as an explanation of your rights related to your medical information.

Pursuant to HIPAA and privacy guidelines, you have a right to access (inspect and copy) protected health information that is created by Neurosurgical Associates in a *designated record set* that is used, in whole or in part, by Neurosurgical Associates to make a decision about you and the health care services provided through Neurosurgical Associates. A *designated record set* is comprised of your medical and billing records and includes protected health information and is maintained, collected, used or disseminated by or for Neurosurgical Associates.

Sincerely,  
Neurosurgical Associates, P.C.

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### **I understand that Neurosurgical Associates may deny access to this information under certain circumstances.**

Acton Corporation is our medical record processing company. They have agreed to provide your personal medical records request at a minimum fee of five dollars (\$5.00) and a maximum fee of twenty dollars (\$20.00). Acton Corporation collects patient records on-site every Tuesday and they will contact you within 2 business days to arrange payment as well as a delivery method for your records.

Acton Corporation is located at:  
13521 Old Highway 280 Suite 141  
Birmingham AL 35242.  
Office Number: 205-408-6030  
E-Mail: [info@actoncorporation.com](mailto:info@actoncorporation.com)  
Website: [www.actoncorporation.com](http://www.actoncorporation.com)

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Signature of Patient or Guardian

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Date

Return signed forms to [neuro@neurosurgicalassoc.com](mailto:neuro@neurosurgicalassoc.com) or Fax to (205) 930-0746  
or by mail to:  
Neurosurgical Associates PC  
800 St. Vincent's Drive North Tower Suite 700  
Birmingham, AL 35205  
Office (205) 933-8981  
Fax (205) 930-0746