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

Neurosurgical Associates, P.C.
Founded in 1969

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.

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

Please see HealthMark Group's website for further instructions and payments.

HealthMark Group
Office Number: 800-659-4035
E-Mail: status@healthmark-group.com
Website: https://healthmark-group.com/

_____ _____
Signature of Patient or Guardian Date

Return signed forms to 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