

- PROCESSED
- TO BE PROCESSED

updated 9/14/2010

RALEIGH NEUROSURGICAL CLINIC

5838 Six Forks Road, Suite 100 ■ Raleigh, NC 27609

PHONE: 919-785-3400 FAX: 919-788-0476

Authorization for: Disclosure Inspection Amendment Of Protected Health Information

MEDICAL RECORD FEE: \$10.00

Patient: _____ **Med. Rec. #** _____

Phone# _____ **Soc. Sec. #** _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip** _____

I hereby authorize _____
Name/Address of person/organization to release records from

To release information from the medical records of _____
Patient name

To: _____
Name/Address of person/organization to which disclosure is to be made

Fax # _____ **Phone#** _____

For treatment dates: _____
*(Specify dates--this line **MUST BE** completed)*

For the following purpose: Medical Care Legal Insurance Other (detail below)

Select Portions

<input type="checkbox"/> Lab <input type="checkbox"/> Hospital Consultations <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Hospital Admission/discharge <input type="checkbox"/> Clinical Notes <input type="checkbox"/> Demographics <input type="checkbox"/> Operative/Procedure Report <input type="checkbox"/> Itemized Statement	<input type="checkbox"/> Entire Record <u>Excluding</u>- HIV Testing & Chemical Dependency <input type="checkbox"/> Entire Record <u>Including</u>- HIV Testing & Chemical Dependency <input type="checkbox"/> Entire Record <u>Including</u>- HIV Testing Only. <input type="checkbox"/> Entire Record <u>Including</u>- Chemical Dependency Only. <input type="checkbox"/> Other _____ _____
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This authorization expires 180 days from the date signed below and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorized the disclosure such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in the reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

Date

Signature of patient/Parent/Guardian

Fees/charges comply with all laws and regulations applicable to release of Protected Health Information. The Minimum charge is \$10.00 per release. Anything over 13 pages will be charged .75 for each additional page. Payment is due at time of release.

<u>FOR OFFICE USE ONLY</u>		
Date records copied _____	No. of pages _____	Instructions _____
Charged Amount _____	Method of Payment _____	Post Date/Initials _____