Authorization for Disclosure of Health Information

I, the undersigned, authorize ***RALEIGH NEUROSURGICAL CLINIC, INC. 5838 SIX FORKS ROAD, STE 100*** **RALEIGH, NC 27609 to release my health information as noted below:**

******All sections must be completed in order for request to be processed******

Patient Information

Patient Full Name: _____

Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Email Address: _____ SSN: _____

Release Information To

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax # _____

Purpose of Request: Perso n al Treatmen t Leg al In suran ce Disability

Information to be Released

Please specify the information to be released:

☐ *Specify Date(s) of Service:*

List: _____

☐ *Entire Chart*

I understand I will receive an invoice from Raleigh Neurosurgical Clinic, INC per North Carolina Statutes and payment is made directly to Raleigh Neurosurgical Clinic, Inc.
Questions about your request or invoice can be answered by calling

Initial Here

We accept VISA, MASTERCARD and AMEX credit cards.
Credit Card Number: _____
Full Name on Card: _____
Exp. Date: _____ **Zip Code** _____
3-Digit Security Code (Back of Card): _____
Comments: _____

North Carolina Statute §90-411: $0.75 for first 25 pages, $0.50 for *pages 26 - 100, $0.25 for pages over 100,* ***Minimum fee of $10.00***.
Charges outlined above will be applied for all copies released directly to patient .The charge does not apply when the records are sent directly to a healthcare

Authorization to Release Protected

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check One			*Initial each line below*
I ☐ **DO**	☐	**DO NOT** want information about ***Mental Health** released	_____
I ☐ **DO**	☐	**DO NOT** want information about ***HIV Tests** & **Related Information** released	_____
I ☐ **DO**	☐	**DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ **DO**	☐	**DO NOT** want information about _____ released	_____

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature _____ **Date:** _____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 180 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by **RALEIGH NEUROSURGICAL CLINIC, INC** and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*

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