□ PROCESSED

□ TO BE PROCESSED

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

☐ ***Lab***	☐ ***Entire Record Excluding- HIV Testing &Chemical Dependency.***
☐ ***Hospital Consultations***	☐ ***Entire Record Including- HIV Testing & Chemical Dependency.***
☐ ***Imaging/Radiology***	☐ ***Entire Record Including- HIV Testing Only.***
☐ ***Hospital Admission/discharge***	☐ ***Entire Record Including- Chemical Dependency Only.***
☐ ***Clinical Notes***	☐ ***Other*** ____________________
☐ ***Demographics***	
☐ ***Operative/Procedure Report***	
☐ ***Itemized Statement***	

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.

FOR OFFICE USE ONLY

Date records copied ***No. of pages*** ***Instructions***