403 Gilead Road, Suite B
Huntersville NC, 28078
(P) 704.464.1509
(F) 704.464.1393
Email: info@ncneuro.com

AUTHORIZATION FOR RELEASE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the release or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. By signing this Authorization, I understand that I am giving my authorization to **North Carolina Neurology and Sleep** (**NCNS**) to disclose/obtain my protected health information ("PHI") as specified in this Authorization. I further understand that if the person or organization I authorize to receive the information is not a health care provider or health plan, the released information may no longer be protected by federal or state privacy regulations.

I authorize NC Neurology & Sleep to disclose or obtain the following information from the medical records of:

Patient Name:		Date of Birth:	
Telephone:		Medical Record #:	
Address:			

RECORDS FROM (Entity **disclosing** information): ____

RECORDS TO (Entity **receiving** information): ____

Covering the period(s) of health care (dates):

From: ____________________ To: ____________________

From: ____________________ To: ____________________

Information to be disclosed:

☐ Complete health record(s)*, including all images (X-rays, CT scan, MRI, Ultrasound, Nuclear Medicine, Mammograms, photographs, etc.)
☐ Complete health record(s)*, excluding all images
☐ Include records from providers other than NCNS (contained in NCNS's records)
☐ Do not include records from providers other than NCNS (contained in NCNS's records)

* Includes any communicable disease, drug and alcohol records and mental health records, except Psychotherapy Notes, for which a separate authorization must be signed.

OR

Select from the following (check as many as apply):

☐ Progress Notes
☐ History and Physical Examination
☐ Consultation Reports
☐ Treatment for alcohol and/or drug abuse
☐ Laboratory Tests
☐ X-ray/Imaging Reports
☐ Billing Records
☐ PSG/EEG Reports
☐ Mental health care or services (does not include Psychotherapy Notes for which a separate authorization must be signed)
☐ For any digital copy of Polysomnography, EEG, Ambulatory EEG. Please specify: ______________________________
☐ Other (please specify) ____

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The purpose of the disclosure is:
☐ Insurance ☐ Moving ☐ Patient Request ☐ Transferring Physicians ☐ Referral
☐ Claim or suit for personal injury. NCNS reserves its rights to a provider lien under N.C.G.S. § 44-49.
☐ Other. Please Specify: ____

This information is to be disclosed to the following individual or entity:

Name:		Relationship:	
Telephone:		Facsimile :	
Address:			

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, that this authorization will expire within six months of signing or on the following date: __________________.
Initials: __________
b. I understand that I may revoke this authorization at any time by notifying NCNS in writing, but if I do it will not have any effect on any actions NCNS took before receiving the revocation.
Initials: __________
c. I understand that NCNS cannot make me sign this authorization as a condition to receive treatment from NCNS except:
(i) When NCNS provides me with research-related treatment in which I have agreed to participate; or
(ii) When I have asked NCNS to provide me with health care solely for the purpose of creating protected health information for disclosure to someone else, such as my employer.

Initials: __________

NCNS, its employees, officers, and physicians involved in my care are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

____ ______________________________
Signature of Patient or Representative Date

____
Print Name Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

____
* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *