Mecklenburg Neurological Associates
Authorization to Use or disclose protected health information.

Patient Name______________________________DOB___________________SSN__________________

Address(street, city,st,zip)____

Please check one of the boxes below for release of medical information:

Release information only to me:☐ Yes ☐ No

☐ All Records **☐ Lab results**
☐ x-ray reports **☐ radiology scans**
☐ physician notes **☐ Other ____**

Release information to spouse or other person listed: ☐ Yes ☐ No

Spouse's Name/other: ____

Release records to other: ☐ Yes ☐ No

Name: _______________________________________ Phone # _________________________________

Address______________________________________City/st/Zip_______________________________

If you need to contact me you may leave messages on my answering machine? ☐ Yes ☐ No

Phone # _____________________This Does/Does Not identify me by name?(circle)

Signature ____ Date: ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

MNA reserves the right to modify the privacy practices outlined in the notice. I understand that the information in my record may include information relating to sexually transmitted diseases, HIV/AIDS, or any other medical condition. It may also include information about behavioral or mental health services or treatment for alcohol and drug use. I also understand my information will be released and shared among healthcare professionals involved in my care and to my insurance plan for processing of claims. I have received a copy of the Notice of Privacy Practices for MNA. I understand in order to revoke this authorization I must do so in writing.

____ ____
Name of Patient (Print) **Signature of Patient**

____ ____
Signature of Patient's Representative **Relationship to Patient**
(Required if the patient is a minor or an adult who is unable to sign this form)

____ ____
MNA Signature **Date**

Expiration of Release ___________________________