

Mecklenburg Neurological Associates

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone: _____ Social Security #: _____

I request and authorize _____
to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I understand this release may include any records regarding, STD, drug, alcohol, or mental health treatment to the person(s) listed above. I have read and understand this authorization and authorize the disclosure of the health information noted above.

I agree that a copy of this release or a fax of this release shall be as valid as this original. I understand that I may withdraw this authorization at any time by submitting such request in writing to Mecklenburg Neurological Associates (MNA). The request to revoke the authorization does not affect any health information disclosed prior to MNA receiving the written request. I release MNA and any and all employees from all liabilities, responsibilities, damages, losses and claims which might arise from the release of authorized information. Please send copies of all requested information to the address or fax number above.

Patient/Guardian
Signature: _____ Date : _____

MNA Signature: _____ Date Released: _____

Method records were released. Fax _____ Mailed _____ In Person _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.

