

Mecklenburg Neurology
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

- | | |
|--|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Lab results |
| <input type="checkbox"/> x-ray reports | <input type="checkbox"/> radiology scans |
| <input type="checkbox"/> physician notes | <input type="checkbox"/> 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)

MN Signature Date

Expiration of Release _____