Crescent
NEUROLOGY AND SLEEP

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RELEASE OF MEDICAL RECORDS

PATIENT'S NAME	DOB	ADDRESS

CHECK ONE :

□ **I HEREBY AUTHORIZE _____ (REFERRED TO HEREIN AS "CRESCENT NEUROLOGY AND SLEEP ") TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON.**

□ **I HEREBY AUTHORIZE CRESCENT NEUROLOGY AND SLEEP TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON TO:**

_____

Name(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made.

□ **I HEREBY AUTHORIZE _____ TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PERSON TO CRESCENT NEUROLOGY AND SLEEP .**

For treatment date(s):

_____

For the following purpose(s):_____

If the request is initiated by the individual (or his/her representative), insert "at the request of individual;" otherwise, describe purpose of the use or disclosure. If the purpose relates to marketing, indicate whether Crescent Neurology and Sleep will receive remuneration.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED

Unless the appropriate box is checked, Crescent Neurology and Sleep will *not* disclose records contained in its medical records prepared by healthcare providers not affiliated with Crescent Neurology and Sleep unless the records were prepared on behalf of Crescent Neurology and Sleep).

□ Demographic Information
□ Payment Records
□ Lab Test Results
□ Admission History & Physical
□ Consultation Reports
□ Operative/Procedure Reports
□ Imaging/Radiology Reports

□ Physician Progress Notes
□ Physician Orders
□ Discharge Summary
□ Nursing Notes
□ Billing Records
□ Other
_____

□ Entire Record (will not include Billing Records or records not prepared by or on behalf of Crescent Neurology and Sleep unless those items also are selected).
□ Records not prepared by or on behalf of Crescent Neurology and Sleep . Crescent Neurology and Sleep cannot be responsible for the completeness or accuracy of such records.

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain _____ records relating to participation in any federally assisted drug and alcohol abuse program; _____ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); _____ information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $15 per request, a copying charge of up to $0.50 for the first 250 pages and $0.35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Crescent Neurology and Sleep's Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Privacy Officer, Crescent Neurology and Sleep , ADDRESS.

_____ _____
Date *Signature of Individual/Individual Representative*

_____ _____
Printed Name of Representative and Relationship *Representative address and telephone number*

_____ _____
Date *Signature of Witness*

ORIGINAL – Crescent Neurology and Sleep . Records COPY – Individual