Neuro Medical Care
ASSOCIATES, PLLC
52 Harrison St 2nd Floor Johnson City, New York 13790

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA REQUEST FOR RECORDS FROM NEURO MEDICAL CARE ASSOCIATES, PLLC

Patient Name (Printed Name) _____ Date of Birth _____

Patient Address _____ Social Security Number: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form; In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that:

1. The authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisplaying such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that the action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2) and this redisclosure my no longer be protected by federal or state law.

6. To release this information:

   NEURO MEDICAL CARE ASSOCIATES, PLLC 52 Harrison Street, Johnson City, NY 13790
   Aamir Rasheed, MD, Taseer Minhas, MD, Dharmesh Patel, MD, Ahmed Alwan, DO, Sherrie Adler, FNP-C

7. Name and address of person(s) or health provider to whom this information will be sent:

   _____

   _____

   _____

8. Specific Information to be released:

   Medical Record from (insert date)_____

   to (insert date)_____

   Entire Medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, and consults.

   Other:_____

   Include(Indicate by Initialing): Alcohol/Drug treatment _____

   Mental Health Information_____ HIV-Related Information _____

9. Reason for release of information: At request of individual _____

   Other: _____

10. Date or event on which this authorization will expire: _____

11. If not the patient, name of person signing form: _____

12. Authority to sign on behalf of patient: _____

All items on this form have been completed and my questions about this form have been answered.

_____ _____

Signature of Patient or representative authorized by law Date