The NeuroMedical Center CLINIC
Experts for the Brain, Spine, & Nervous System

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

10101 Park Rowe Avenue, Suite 200
Baton Rouge, LA 70810
Phone: 225.769.2200
TheNeuroMedicalCenter.com

Patient Name:_____ **Patient Account Number:**_____

Date of Birth:_____ **Home Phone:** _____ **Cell Phone:**_____

Address:_____

Is this address where you want the medical records sent? □Yes or □No (If NO, please list alternate address)
Alternative Address:_____

1. The following individual or organization is authorized to make the disclosure:

The NeuroMedical Center Clinic
Attention: Clinic Medical Records Department
10101 Park Rowe Avenue · Suite 200
Baton Rouge, LA 70810
Phone: 225.769.2200 · Fax: 225.768.2196

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate):

	Progress Notes		Consultation Reports		Laboratory Tests
	X-Ray Test/Reports		History & Physical Examination		
	CD of Images - Specify:				
	Discharge Summary	FROM (date):	TO (date):		
	Itemized Billing Statement	FROM (date):	TO (date):		
	All PHI in medical record	FROM (doctor's name):			

Other:_____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization.: (If you would like to give a family member or another individual/organization access to your medical records, please list their name(s) and address below).

_____
_____
For the purpose of:_____

5. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 12 months from date signed.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information that carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Privacy Officer at (225) 768-2065.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Relationship to Patient if signed by Patient Representative **Signature of Witness**

• **Please allow 3 to 7 business days for the complete processing of your request. Upon completion you will receive an invoice from the company IOD. This is our contracted release of information provider.** • **If your medical records are being directly sent to a physician there will be no charge.**	**Delivered through Mail on paper** **$.036/per page (1-200)** **$.012/per page (201+)** ***Max charge of $400**	**Xray Films in Electronic Format** **$1.00/image (images 1-25)** **$25 maximum fee**

Rev. 11/16/2015 **Received by** _____ **Date**_____
In accordance with Louisiana Revised Statues 40:1299.96. This information can be found at: http://www.legis.state.la.us/lss/lss.asp?doc=97291