TRUE NORTH NEUROLOGY
Tel: 631-364-9119 FAX: 855-644-2983

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:
_____**DOB:**_____

Address: _____ **Phone:** _____

Requested Information:

- ☐ **All medical Records**
- ☐ **Radiology (X-Ray, MRI, etc.)**
- ☐ **Laboratory Testing**
- ☐ **Consults**
- ☐ **Diagnostic Studies**
- ☐ **Progress Notes**
- ☐ **Other**_____

☐ **Dates of Treatment: From** _____ **To** _____

I understand that my medical record may include a wide variety of inpatient and outpatient information on diagnosis, treatment and procedures including psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS) and (HIV) status.

For the purpose of: **CONTINUTY OF CARE**

_____

RELEASE FROM: TRUE NORTH NEUROLOGY

TEL: 631-364-9119 **FAX: 855-644-2943**

RELEASE TO:

_____

ADDRESS: _____

PHONE: _____

FAX: _____

I understand that I have a right to revoke this authorization at any time. I understand that if revoke this authorization, I must do so in writing and present my written revocation to a staff member of True North Neurology, I understand that the revocation will not apply to information that has already been released by the authorization. This authorization will be expired 12 months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the office manager at the practice. New York State Law Section 17 and 18 of the Public Health Law, Chapter 165, section 48 & 49, states $0.75 per page plus postage for your medical record is legal charge that is permitted.

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Print Name of Patient or Guardian **If not signed by patient, please indicate**