MECKLENBURG NEUROLOGY

Authorization to Use or disclose protected health information.

Patient Name_____DOB_____SSN_____

Address (street, city, state, zip)_____

Please check one of the boxes below for release of medical information:

Release information only to me: ___Yes ___No

- All Records
- X-ray reports
- Physician notes
- Lab results
- Radiology scans
- 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

MNG 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 MNG. '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 (Required if the patient is a minor or an adult who is unable to sign this form)

Relationship to Patient

_____ _____

MNG Signature Date

Expiration of Release 180 days after it is signed