

**Asheville Neurology Specialists, P.A.**  
**Patient Request to Review or for Copies of Records**

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

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**Name & address of Covered Entity authorized to release information:**

Asheville Neurology Specialists, P.A., 1200 Ridgefield Blvd., Ste. 250, Asheville, NC 28806

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**Name & address of entity to receive/review information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Description of information to be released/reviewed at the request of the patient:**

\_\_\_\_\_  
\_\_\_\_\_

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**Rights of the Patient**

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until I revoke it; at which time this authorization to use or disclose this protected health information expires.

\_\_\_\_\_  
Signature of Patient or Personal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Print or Type Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)