

Asheville Neurology Specialists, P.A. Authorization to Obtain Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

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

Forward information to:

Asheville Neurology Specialists, P.A.
1200 Ridgefield Blvd., Ste. 250
Asheville, NC 28806
Telephone: (828) 210-9300 Fax: (828) 210-9319

The information below will be used for patient care. Description of the protected health information to be disclosed and needed:_____

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

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information 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.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the practice's Privacy Contact at Asheville Neurology Specialists, PA, 1200 Ridgefield Blvd., Ste. 250, Asheville, NC 28806.

Signature of Patient or Personal Representative

Date _____

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