Authorization to Release/Request Health Information

Asheville Neurology Specialists
31 Dogwood Rd, Asheville, NC 28806
Phone: (828) 210-9300 Fax: (828) 210-9319

Patient Information:

Name of Patient_____Date of Birth _____

Address_____

City, State, Zip_____Phone _____

Asheville Neurology Specialists, PA may RELEASE or REQUEST (circle one) the following information:

☐ Entire record ☐ Financial Records ☐ Office Visit Notes

☐ Labs ☐ Imaging/Diagnostic Tests ☐ FMLA/Disability Info

☐ Other as listed _____

*We charge a fee for records that are printed and/or mailed. We do not charge for records sent via fax/electronically.

Entity or person who will RELEASE or RECIEVE (circle one) the information:

Name_____

Address_____

Phone _____Fax _____

☐ **Send the information electronically to mail address: _____**

_____(Initial Here) For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Revised March 2019