AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ SS # _____ Date of Birth _____

Street Address _____ City, State, Zip _____

I hereby authorize:

Name _____

Street Address _____

City, State, Zip _____

Phone # _____

Fax # _____

To disclose my protected health information to:

CAROLINA NEUROLOGY OF SPARTANBURG

541 FLOYD RD

SPARTANBURG, SC 29307

Phone: 864-585-6179

Fax: 864-583-5403

Information to be released:

____ Medical History, Examination Reports
____ Treatment or Tests
____ X-ray reports
____ Laboratory Reports
____ HIV Test Results
____ Mental Health
____ Sexually Transmitted Diseases
____ Alcoholism
____ Sleep Studies
____ Surgical Reports
____ Hospital Records including Reports
____ Developmental Disabilities
____ Prescriptions
____ Consultations
____ Allergy Records
____ Drug Abuse
____ Nerve Conduction/EMG reports
____ Other (Please Specify) _____

*A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose of Disclosure:
____At the Request of the individual
____Other (Please Specify) _____
_____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:
- ► Receive a copy of this authorization
- ► Refuse to sign this authorization and that treatment, payment, enrollment in a health plan, or eligibility for health care benefits may not be contingent on my signing this authorization.
- ► Revoke this authorization, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until □ infinitely or until the following date _____.

Signature of Patient (or Legal Representative) _____ Date _____

Relationship to Patient (If signed by legal representative) _____ Date _____