AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

______________________________	______________________	____________
Name of Patient	SS #	Date of Birth

______________________________	______________________________
Street Address	City, State, Zip

I hereby authorize:

CAROLINA NEUROLOGY OF SPARTANBURG

541 FLOYD RD

SPARTANBURG, SC 29307

Phone: 864-585-6179

Fax: 864-583-5403

To disclose my protected health information to:

____
Name

____
Street Address

____
City, State, Zip

____
Phone #

____
Fax #

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