


AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ SSN# (Optional) _____

 <p style="text-align: center;">THE NEUROHEALTH SCIENCES CENTER, LLC</p> <p style="text-align: center;">200 N. Mangoustine Ave. Sanford, FL 32771 FAX: 407-833-7509</p> <p>PH: 407-833-7505</p>	<p align="center"><u>REQUESTOR OF INFORMATION:</u></p> <p><input type="checkbox"/> Self <input type="checkbox"/> Other: _____</p> <p>Address: _____ _____ _____</p> <p>PH: _____</p>
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Description	Date(s)	Description	Date(s)	Description	Date(s)
<input type="checkbox"/> Admission Forms <input type="checkbox"/> Physician Dictated Reports <input type="checkbox"/> Physician Orders <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> ER Documentation <input type="checkbox"/> X-Ray reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> EKG(s)		<input type="checkbox"/> Operative Documentation <input type="checkbox"/> Invasive Procedure Documentation <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Nursing Documentation <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Entire Medical Record		<p align="center"><u>SUPER-CONFIDENTIAL INFORMATION</u></p> <input type="checkbox"/> HIV Testing <input type="checkbox"/> HIV & AIDS Documentation <input type="checkbox"/> Psychiatric Documentation <input type="checkbox"/> Alcohol & Drug Abuse Documentation <input type="checkbox"/> Other: _____	

Purpose of Disclosure (Please Specify):

Continuing Care with another physician of hospital Personal Copy Other (Please Specify): _____

Authorization:

I understand that:

1. This authorization will remain in effect for 30 days.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient/Guardian/
Representative Signature: _____ Date: _____

Patient/Guardian/
Representative Printed Name: _____ Date: _____

Witness Signature: _____ Date: _____