# Authorization for Disclosure of Health Information

Phone 757-461-5400
Fax 757-461-3305

I, the undersigned, authorize **NEUROLOGY SPECIALISTS, 6161 Kempsville Circle, Suite 315 Norfolk, Virginia 23502** to release my health information as noted below:
Please return the **COMPLETED** authorization to this address.

## Patient Information

***All sections must be completed in order for request to be processed***

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone#: _____

Email Address: _____ ☐ Release Records to e-mail

## Release Information To: (THIS SECTION MUST BE COMPLETED)

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Referral by NS To Another Provider/Phys. Therapy ☐ Second Opinion OR Transfer of Care to Another Physician

☐ Personal Records ☐ Other/Reason _____

## Information to be Released

**Please specify the information to be released:**

☐ Office Notes ☐ Labs ☐ Neuropsychology Notes/Testing ☐ Diagnostic Reports

Specify Date(s) of Service: _____

***** PAYMENT OPTIONS: Check, Credit Card or Money Order**

Charges outlined below will be applied for all copies released directly to patient or sent on patient behalf.

***Invoice must be paid before records will be released.**

***All Fees are based on HIPAA guidelines***
***(Code of VA §8.01-413 applies)***
- ***Pages 1 – 50 = $0.50 each Page***
- ***Pages 51 & above = $0.25 each Page***

***Plus all postage and handling costs***

STOP _____ *Initial Here*

**I understand BACTES Imaging will MAIL an invoice for records per Virginia Statutes and payment is made directly to **BACTES Imaging. Questions about your request or invoice can be answered by calling: (877) 270-4365**

## Authorization to Release Protected Health Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

*Check one* *Initial each line below*

☐ **I DO** ☐ **DO NOT** want information about ***Mental Health/Neuropsychology** released _____
☐ **I DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
☐ **I DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
☐ **I DO** ☐ **DO NOT** want information about _____ released _____

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete we may be unable to fulfill this request.

**Patient's Signature**_____**Date:**_____
(Required for all patients 18 years and older.)

**Signature of Parent or Legal Guardian**_____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by **NEUROLOGY SPECIALISTS** is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*