COASTAL
NEUROLOGY AND NEUROSURGERY

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient name: _____ D.O.B:_____ SSN#_____

I authorize Coastal Neurology and Neurosurgery:

_____ *Obtain my medical records from:*
_____
_____
_____
_____

_____ *Release my medical records to:*
_____
_____
_____
_____

By ***initialing*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____Please send the entire medical record (all information) to the above named recipient.

OR

_____All hospital records (including nursing records & progress notes)
_____Operative reports
_____Medical records needed for continuity of care
_____Most recent five-year history
_____Emergency and urgent care records
_____Other:_____

_____ Office chart notes
_____Laboratory reports
_____Pathology reports
_____Diagnostic imaging/X-ray reports
_____Billing statement/Full account ledger

***The following items must be initialed to be included in the use or disclosure of other health information**

_____*HIV/AIDS related health information and/or records
_____*Mental health information and/or records
_____*Genetic testing information and/or records
_____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information)
_____***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any time by giving written notice to the Medial Records Department at CNN. Unless revoked earlier, this authorization will expire **365 days** from the date of signing or upon_____

(Expiration Date)

_____ _____
Signature of Individual or Individual's Legal Representative **Date**

_____ _____
Print Name of Legal Representative (if Applicable) **Date**

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