# Authorization to Disclosure Health Information

# NKL Neurology

I, the undersigned, would like to request a copy of my medical records for personal use

## Patient Infomation

Patient First Name:_____ Patient Last Name: _____

Other Names During Treatment? _____ Date of Birth: _____

## Release Information To

*-This box must be complete in order for request to be processed-*

Address: _____ Phone: _____

City: _____ State _____ Zip:_____ Fax: _____

E-mail:_____

## Information to be Released

1. There will be a $15 flat fee as well as a $.25 per page fee for all requests.

2. Please provide information in my medical record for dates:
From_____ To_____

3. Please check the boxes to the right for information being requested.

- ☐ Complete Health Record
- ☐ Office Visit Notes
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-Rays/Imaging Reports

## Authorization to Release Protected

***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** 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 ***Communicable Diseases** 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, or if protected information is not released, we may be unable to fulfill this request.

**Patient's Signature**_____**Date:**_____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

**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 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital 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 NKL Neurology and its affiliates is 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.*

Rev. 8/20/2012