Advanced Neurologic Associates, Inc.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Notice to Patient: The physician-patient relationship, the federal Health Insurance Portability and Accountability Act, and principles of Ohio law protect the confidentiality of your health information.

SECTION 1: PATIENT INFORMATION

Patient Name (*First, Middle, Last*):		
Patient Address:		
Patient Date of Birth: / /	Last 4 Digits of SSN:	Patient Email Address:
Patient Phone Number: ( )	Alternate Phone Number: ( )	ANA Physician/Provider Name:

SECTION 2: DESTINATION FOR RELEASE OF INFORMATION (Please send records to:)

Organization/Provider Name:		
Address (Street Number and Name, City, State, Zip):		
Phone Number: ( )	Fax Number: ( )	Contact Name/Send to Attention of:

SECTION 3: SPECIFIC AUTHORIZATION

Reason for Requested Release of Information *(Personal use, care coordination, legal, etc.)*. Required Field:

Release the following Records (select one):

☐ ALL RECORDS ☐ LIMITED RECORDS: SPECIFY DATES OR TYPES OF RECORDS:

If you selected "Limited Records" please indicate as specifically as possible which records you are authorizing for release. Such clarification should include either a type of record (a specific test or tests) or records pertaining to a certain date or rage of dates (e.g. Office visit, 9/25/16 or all Office visits in 2016 or all EMG results, etc.):

Phone Number: ( )	Fax Number: ( )	Contact Name/Send to Attention of:

I, the undersigned, authorize Advanced Neurologic Associates, Inc. to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/ drug abuse. This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Advanced Neurologic Associates, Inc. Any revocation will not apply to any information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider. If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ / _____ / ____/____/____

Signature of Patient or authorized Representative[1] Printed Name Date Signed

_____

Relationship, if not Patient

[1]Unless in the case of a parent signing for their child under the age of 18, anyone signing for a patient must present proper identification and legal authorization to do so (court appointed guardian, power of attorney, probate court order or letter of appointment, or similar legal authority). ANA reserves the right to request additional proof of legal authority prior to releasing information.