INLAND NEUROLOGY

Request of Medical Information

Authorization

Patient Name: _____ Patient Date of Birth: _____

Patient Address:_____

Patient last 4 digits of Social Security: _____ Patient Telephone Number: _____

Record Holder

Hospital, Medical Group, Physician Name: _____

Hospital, Medical Group, Physician Telephone Number: _____

Hospital, Medical Group, Physician Fax Number: _____

Records May Be Released To:

Type of Information

_____ Discharge Summary _____ Emergency Dept Reports _____ Psychiatric Records

_____ Progress Notes _____ Laboratory Results _____ Billing Information

_____ Doctor's Orders _____ Any and All Records _____ Radiology/Nuclear Med Reports

_____ History/Physical Exam _____ Treatment Alcohol/Drug Abuse _____ Operative/Procedure Reports

_____ Consultation Reports _____ HIV Test Results (Human Immunodeficiency Virus)

_____ Other (Please Specify)_____

Dates of Service

- From: ___/___/____
- To: ___/___/____

Use of Information

The individual or entity identified above is permitted to use my information for the following purposes: (Please initial all that apply)

_____Transfer of Care _____ Second Opinion _____Personal _____Insurance _____Legal

_____ Continuing Care _____ Other (Please Specify)_____

Duration

- This authorization is valid for one year from the date next to my signature, unless otherwise noted here:
  ___/___/____

Additional Copy

- I further understand that I have a right to receive a copy of this authorization upon my request.

Redisclosure

- I understand that once received, my records will be subject to re-disclosure and my no longer be protected by federal privacy laws.

Revocation

- This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt but will not be effective to the extent that the Requester is specifically required or permitted by law.

Explanation

- I understand that my treatment is no way conditioned on whether I sign the authorization and that I may refuse to sign it.

Signature

Patient Name Printed: _____ Patient Date of Birth: _____

Patient Signature: _____ Date Signed: _____

If signed by someone other than the patient, indicate relationship to patient: _____

Witness Signature: _____ Date/Time: _____

- ❖ Legal documentation along with a valid ID must be provided to prove authority to sign on the patient's behalf