AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

10101 Park Rowe Avenue, Suite 200
Baton Rouge, LA 70810
Phone: 225.769.2200
TheNeuroMedicalCenter.com

Patient Name:__________________________________ **Patient Account Number:**__________________________________

Date of Birth:___________________ **Home Phone:** ________________________ **Cell Phone:**_______________________

Address:____

Is this address where you want the medical records sent? ☐Yes or ☐No (If NO, please list alternate address)
Organization Name: ____

Alternative Address:____

1. The following individual or organization is authorized to make the disclosure:

The NeuroMedical Center Clinic
Attention: Clinic Medical Records Department
10101 Park Rowe Avenue · Suite 200
Baton Rouge, LA 70810
Phone: 225.769.2200 · Fax: 225.768.2196

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate):

	Progress Notes		Consultation Reports		Laboratory Tests
	X-Ray Test/Reports		History & Physical Examination		
	CD of Images - Specify:				
	Discharge Summary FROM (date): TO (date):				
	Itemized Billing Statement FROM (date): TO (date):				
	All PHI in medical record FROM (doctor's name):				

Other:____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services, and treatment for alcohol and drug abuse.

4. If you would like to give a family member or another individual access to your medical records, please list their name(s) and address below.

____
____
For the purpose of:____

5. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition______________________________**.** If I fail to specify an expiration date, event, or condition, this authorization will expire 12 months from date signed.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information that carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Privacy Officer at (225) 768-2065.

____ ________________________
Signature of Patient or Personal Representative **Date**

____ ________________________
Relationship to Patient if signed by Patient Representative **Signature of Witness**

• **Please allow 3 to 7 business days for the complete processing of your request. Upon completion you will receive an invoice from the company MedSouth. This is our contracted release of information provider.** • **If your medical records are being directly sent to a physician there will be no charge.**	***Paper records are $6.50 flat rate*** ***Disc of images are $10.00 flat rate***

NMC 1012 (Rev. 11/18)

Received by ____________________________________ **Date**______________________

In accordance with Louisiana Revised Statues 40:1299.96. This information can be found at: http://www.legis.state.la.us/lss/lss.asp?doc=97291