

MEDICAL RECORDS AUTHORIZATION

Patient's Full Name

Patient's Social Security Number/ DOB

Address:

Telephone:

I hereby authorize Mclean County Neurology to disclose my Protected Health Information.

The following person, class of persons or facility may receive my Protected Health Information:

Name

Address

The specific information that should be disclosed is (please give dates of service if possible):

1. I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by written notification to McLean County Neurology. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. This authorization expires one year from date.

Signature of Patient

Date

OR, if applicable –

Signature of Guardian or
Personal Representative of Patient's Estate

Date

SIGN HERE IF YOU WANT INFORMATION REGARDING MENTAL HEALTH, ALCOHOL/SUBSTANCE ABUSE AND OR HIV/AIDS DISCLOSED:

YES, DISCLOSE THIS INFORMATION _____

Signature of Patient

Date