

MEDICAL RECORDS AUTHORIZATION

Patient's Full Name

Patient's Social Security Number/ DOB

Address:

Telephone:

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

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

To: McLean County Neurology, S.C.
2204 Eastland Drive ~ Bloomington, Illinois 61704
(309) 662-9461 ~ fax: (309) 663-0222

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

- _____

2. I understand that the information 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.
3. I may revoke this authorization by written notification to the recipient. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. 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

Federal and state laws permit a fee to be charged for copying patient records.