Authorization to Disclose Protected Health Information
The undersigned authorizes **Neurology Specialists**
6161 Kempsville Circle, Suite 315, Norfolk, VA 23502
Fax: (757) 461-3305
to release my health information as noted below:
******All sections must be completed in order for request to be processed******

Patient Information

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____ **Other Names?** _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To (THIS SECTION MUST BE COMPLETED)

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address and name of your designated recipient if electronic delivery is chosen.

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Information to be Released (THIS SECTION MUST BE COMPLETED)

If you fail to specify, 1 year of records will be provided.

☐ Office Notes ☐ Labs ☐ Diagnostic Reports

Specify Date(s) of Service: _____

☐ **Other** (please specify):

_____

Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at (866) 967-0133

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.
At no time will the cost-based fees exceed VA law (Statute: §8.01-413)

I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

DELIVERY METHOD	[ ] Send by Email*	[ ] Mail Records on CD	[ ] Mail Records on Paper

A valid email must be provided above. If you do not select a delivery method, Sharecare will determine the delivery method based on the information provided on this form.* **No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial*)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**
_____. *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*