CONSENT TO RELEASE HEALTH INFORMATION

Neuroasis
Medical Record Management
4578 N. First Avenue, Suite 100, Tucson, AZ 85718
Telephone: (520) 338-2557
FAX: (520) 844-9535

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment, or health care operations. In our Notice of Privacy Practices, we provided you information about how Neuroasis can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this authorization.

Please neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____

Birth Date _____

Authorization for Neuroasis to receive information ☐
Authorization for Neuroasis to release information ☐

By signing this form, I am allowing Neuroasis to release or obtain medical information concerning the above named patient to or from the person or facility listed below. If you are requesting information for yourself or for a third party, Neuroasis will assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

Paper Copy ___ CD ___ Electronic____ Verbal____

_____

Name of Person and/or Institution who will **receive or release** information:

_____

Complete Mailing Address:

Street or PO Box: _____

City, State, Zip Code_____

Check the information to be disclosed (include dates if known):

☐ I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

☐ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Genetic Testing
  Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.
- □ Other (please specify): _____

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records that Federal Law protects those records. The authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibits information disclosed from records protected by this law from being re-disclosed, even to the patient, without a specific written consent of the person to whom it pertains or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rule restricts any use of the information to criminally investigate or prosecute the patient.

Please check the reason for sending or receiving information below; and provide a date by which the info is needed: _____

Insurance ____ 2nd opinion _____ Rehab/disability _____ Personal file _____ Moving out of area _____ Legal _____ Other medical care _____ Transferring care _____

If transferring care, may we confidentially discuss with you? YES ___ NO___
If yes, please indicate the best time and telephone number to reach you:
_____

This consent is voluntary. If I cancel this consent before expiration, I must send written notification to the Medical Record Management Team at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the

disclosed information or ask questions by contacting the Medical Record Management Team at the above address.

Neuroasis does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

This agreement will expire **one-year** from the date of signature, or as indicated

specifically, by you: _____ (date, months, day, year).

Print Name: _____

Signature: _____

Date: _____

Relationship, if Not the Patient: _____

Witness Signature _____

_____

Neuroasis use only:
This release is to be entered into the patients chart for future reference.

_____ Date Received

Entered to chart by: _____

Date of records sent: _____

Date records received: _____