Northwest Neurology

AUTHORIZATION TO RELEASE INFORMATION

Patient Name (Print): _____

Date of Birth: _____ Telephone Number: _____

Date(s) of Service: _____ Possible Other Name: _____

[ ] I hereby authorize Northwest Neurology, Ltd. to release information to:

Person/Facility: _____

Address: _____ City/State/Zip: _____

Telephone Number: _____ Fax Number: _____

[ ] I hereby authorize _____ to release information to:

Northwest Neurology, Ltd.
22285 N. Pepper Road, Suite 401 - Lake Barrington, IL 60010
Tel (847) 882-6604 Fax (847) 882-6228

Authorization to release: [ ] Progress/ Office Notes [ ] Labs [ ] MRI [ ] EMG [ ] EEG
Other: _____

Authorization to release sensitive information as indicated:
[ ] Drug [ ] Alcohol [ ] Behavioral Health [ ] Psychiatric information

This information will be used/disclosed for the follow purpose:
[ ] Continuing care [ ] Personal [ ] Legal Other _____

NOTICE TO PATIENT

I fully understand that my medical record for the above dates of service may contain drug, alcohol, behavioral health and/or psychiatric information as well as Acquired Immune Deficiency Syndrome/HIV test results and other sensitive information. I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if: **A.)** Action has been taken in reliance of this authorization: or **B.)** If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy of the policy itself. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This consent will be valid for one year from the signature date, or until _____

Patient Signature: _____ Date: _____

Legal Representative: _____ Relationship: _____

Witness: _____ Date: _____