Novus Neurology

2201 Jack Warner Parkway, Tuscaloosa, AL 35401
Phone (205) 523-5618 FAX (659) 210-3460

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I understand that Novus Neurology is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose information, and the recipient (s) of that information. I specifically authorize any current employee or owner of Novus Neurology, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the step set forth below.

I _____ authorize that Novus Neurology to:

_____ Release to:

_____ Obtain from:

Facility/MD Name:_____

Address:_____

Phone: _____Fax:_____

Date range requested: _____ all past dates _____date range: from _____to _____

Description of Information to be used or disclosed:

___ The patient's entire medical record

___ Labs

___ Imaging Report(s)_____ mail CD of images to address above

___ Other (specify):_____

For the purpose of:

___ Evaluation/assessment and/or continuation of care

___ Other (specify):_____

Fax all requested records to: (659) 210-3460

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released). All revocations must be sent to Novus Neurology to the attention of the Privacy Officer, Jordan Baumgarten, and are not effective until received by the Privacy Officer.

This consent will automatically expire one (1) year after the date of my signature as it appears below.

_____ Date of Birth:_____

Patient Printed Name

_____ Date:_____

Signature of Patient