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 (PHI) 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 (Last name/First name):_____ , _____ Date of birth: ___/___/___
authorize Novus Neurology to obtain PHI from:

Facility/MD Name:_____
Address:_____
Phone: (____)_____-_____ Fax:_(____)_____-_____

Please Include

- Most recent colonoscopy, mammogram, pap smear, Dexa scan
- Most recent Cardiology test (ECG, Echocardiogram, Stress test) if available
- All vaccine records

Date range of the following (check/ fill one):

☐ **Prior 2 calendar years from signed date to present (preferred)**
☐ ___/___/___ to Present (other dates if specific need)

The patient's entire medical record to include:

- Office visits
- Lab results
- Other in-office diagnostic tests (e.g. spirometry/ PFTs, audiometry)

For the purpose of evaluation/assessment and/or continuation of care

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 below.

_____
Patient Printed Name

_____ Date:_____
Signature of Patient