CENTER FOR NEUROLOGICAL STUDIES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA)

TO: _____
PATIENT: _____
DOB: _____
RELEASE TO: Center for Neurological Studies - 330 Town Center Dr – Suite 710 - Dearborn, MI 48126

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following conditions:

__X__ Drug Abuse, if any
__X__ Sickle Cell Anemia, if any
__X__ Alcoholism or alcohol abuse, if any
__X__ Psychological or psychiatric conditions, if any

Information Requested:

__X__ Entire Medical Record
__X__ History and physical, discharge summary and operative reports
__X__ Any and all office records
__X__ Diagnostic reports, including x-rays, MRI, CT, lab results
__X__ Outpatient and E.R. admissions
__X__ Billing, insurance and payment information
_____ Other _____

Dates Covered:

__X__ All admissions or care at this facility or by this doctor
_____ Limited to treatment dates for conditions described: _____

Purpose(s) or need for which information is to be used:

__X__ Damages or claims evaluation and presentation of personal injury matter.
_____ Other _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected under the Health Insurance Portability and Accountability Act of 1996.

Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event:
_____ on _____ (date supplied by patient): or
__X__ if revoked in writing by patient; ___ 1 year from the date hereof; _X_ 3 years from the date hereof, or under the following condition: _____

The authorization for the disclosure of this health information is voluntary. The provider cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law.

Other Conditions: A copy of this authorization or my signature thereon: _X_ may, ___ may not be utilized with the same effectiveness as an original.

_____ Date

_____ Signature: