NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office 703.876.0800 | Fax 703.876.0866 | After hours emergency 703.755.1450

Authorization for Disclosure of Health Information

I, the undersigned, authorize **NEUROLOGY CENTER OF FAIRFAX , LTD. 3020 Hamaker Court, Suite 400 Fairfax, VA 22031** to release my health information as noted below:
Please return the **COMPLETED** authorization to this address or fax to 703-876-0258.

Patient Information

******All sections must be completed in order for request to be processed******

Patient Full Name: _____ Other Names During Treatment? _____
Patient Address: _____ Date of Birth: _____
City: _____ State _____ Zip: _____ Phone#: _____
Email Address: _____ NCF Patient Number: _____

Release Information To: (THIS SECTION MUST BE COMPLETED)

Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Referral by NCF to Another Provider/Phys. Therapy ☐ Second Opinion OR Transfer of Care to Another Physician
☐ Personal Records ☐ Other/Reason _____

Information to be Released

Please specify the information to be released:

☐ Office Notes ☐ Labs ☐ Testing from NCF
☐ Radiology (Reports ONLY) ☐ **Entire Chart**

Other (specify): _____

Specify Date(s) of Service: _____

**NOTE: OBTAIN INFORMATION FROM OTHER DOCTORS OR PROVIDERS DIRECTLY FROM THEM.

STOP _____ *Initial Here*

***** PAYMENT OPTIONS: Check, Credit Card or Money Order**
Charges outlined below will be applied for all copies released directly to patient or sent on patient behalf.
***Invoice must be paid before records will be released.**

All Fees are based on HIPAA guidelines
(Code of VA §8.01-413 applies)
- ***Pages 1 – 50 = $0.50 each Page***
- ***Pages 51 & above = $0.25 each Page***

Plus all postage and handling costs

I understand BACTES Imaging will MAIL an invoice for records per Virginia Statutes and payment is made directly to **BACTES Imaging. Questions about your request or invoice can be answered by calling: (877) 270-4365

Authorization to Release Protected Health Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

☐ **I DO** ☐ **DO NOT** want information about ***Mental Health** released _____
☐ **I DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
☐ **I DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
☐ **I DO** ☐ **DO NOT** want information about _____ released _____

"Other sensitive information?"

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete we may be unable to fulfill this request.

- *This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by **NEUROLOGY CENTER OF FAIRFAX** is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older)

Signature of Parent or Legal Guardian_____**Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

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