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 Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

Authorization to Release PHI

Patient Name: _____ Patient D.O.B.: _____ Date : _____

Person Receiving Medical Records : _____
If records are being requested by legal guardian, ***Power of Attorney form*** *needs to be sent to NCF before records can be released.*

Person Receiving Medical Records Address: _____
Fax Number: _____
Email: _____

Records to send

- ☐ Office Notes
- ☐ Laboratory Tests
- ☐ Insurance information
- ☐ Billing statements
- ☐ MRI
- ☐ EEG
- ☐ CAT Scan
- ☐ Forms
- ☐ EMG
- ☐ MRA
- ☐ Letter
- ☐ Other: _____

Request specifications

Reason for Request: _____
Records Start Date: _____
Records End Date: _____
Expiration Date: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

By signing this authorization, I authorize Neurology Center of Fairfax, Ltd. to use and/or disclose certain protected health information (PHI) about me.

When my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy rules. I have the right to revoke this authorization in writing. My written revocation must be submitted to the Privacy Officer at the Neurology Center of Fairfax: 3020 Hamaker Ct #400, Fairfax, VA 22031.

This authorization will automatically expire 1 year from date signed unless otherwise indicated.

Signature: _____ Date: _____

NEUROLOGY CENTER OF FAIRFAX, LTD.

Authorization to Disclose Protected Health Information
The undersigned authorizes Neurology Center of Fairfax, LTD.
3020 Hamaker Court, Suite 400, Fairfax, VA, 22031
(P) (703) 876-0800 ext. 5004 (F) (703) 876-0258
to release my health information as noted below:

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ Date of Birth: _____

City:_____ State: _____ Zip: _____ Phone #: _____

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Name/Facility:_____**Attention:** _____

Address:_____Phone: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: Personal ____ Treatment ____ Legal ____ Insurance ____ Transfer ____ Other:____

Information to be Released

If you fail to specify, a 1-year abstract will be provided.

___Please release a **1-year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2-year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**:_____:

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: _____

___**Radiology Disc**

(**Please pick ONE delivery option**)

[ ] Send by Email **[ ] Records on CD**	**[ ] Fax to Doctor**	**[ ] Records on Paper**

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed VA Statute: §8.01-413

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(*Please Initial*)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety – if form is incomplete, or protected information is not released, we may be unable to fulfill this request.

Signature*: _____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy -of the legal documentation for patient's representative must be supplied with a copy of this form.*