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

Disability Packet

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

Person Receiving Medical Records: _____

*If records are being requested by legal guardian, **Power of Attorney form** need to be sent to NCF before records can be released.*

Person Receiving Medical Records Address: _____

Fax Number: _____

Email: _____

Records to send

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

Reason for request: _____

Records start date: _____

Records end date: _____

Expiration date: _____

Authorization to Release Protected Health Information (PHI)

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: _____

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Disability information

Disability form title: _____

What NCF doctor are you requesting to review your disability evaluation?: _____

Date symptoms began: _____

Date disability began: _____

Date diagnosis was made: _____

Diagnosis for disability: _____

Last day worked: _____

If working part time, date began: _____

What is your current job title, description, and necessary duties?

_____

_____

What functions of your job are you unable to complete due to your condition or disability?

_____

_____

Which symptoms of your condition are preventing or restricting your ability to perform the duties of your job? What accommodations are you requesting? Please be specific.

_____

_____

What aspects of your job can you not perform?: _____

If you are not working, who certified work disability?: _____

When were you certified for work disability?: _____

Are applying for short term or long-term disability?: ____ Short Term ____ Long Term

Why are you disabled?: _____

What physical and/or mental activities are you unable to perform?: _____

What aspects of daily living are limited or cannot be performed?:

_____

List cognitive and/or memory problems:

_____

_____

Additional information:

_____

_____

_____

_____

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.*