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

MEDICAL INFORMATION RELEASE FORM/AUTHORIZATION TO RELEASE PHI

Patient Name: _____ DOB: _____

This form is used to authorize access and disclosure of Protected Health Information (PHI) to third parties (such as family members or close friends). This form authorizes the specific persons named below to have access to your medical information. We respect your right to tell us who you want involved in your treatment or to help you with payment issues. This form is not used to order medical records to be sent to others.

Our secure patient portal is our primary means of patient communication, such as to share your test results. YOU have the ability to control access to your portal. If you wish you may give someone else access to your secure patient portal. You can set this up through the patient portal or you can contact our IT department at 703-564-0060.

Note that we do NOT share your information by e-mail.

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1. I authorize the Neurology Center of Fairfax to disclose the described information:

☐ All records, tests/results, treatment plans ☐ Other: _____

2. I authorize Neurology Center of Fairfax to share details of my medical care with the following individuals:

Name	Relationship	Phone number
1.		
2.		
3.		
4.		
5.		

3. The purpose of these authorizations is:

☐ Healthcare & Treatment ☐ Other: _____

4. **<u>This Authorization will remain in effect until:</u>**

☐ Date: _____ ☐ Indefinitely ☐ Until revoked in writing by me

I have the right to revoke this authorization in writing at any time, except to the extent that NCF has already acted on it. If I revoke this authorization, I agree to send it in writing to NCF at the following address: Privacy Officer, Neurology Center of Fairfax, 3020 Hamaker Court, Suite 400, Fairfax VA 22031.

5. I understand that information used or disclosed under this authorization might be redisclosed by the recipient. As a result, the information is no longer protected to the same extent of the law that it is when under the sole possession of NCF. I hereby hold NCF harmless for any uses of my Protected Health Information (PHI) made by the person/s or organizations whom I have authorized.

Signature: _____ Date: _____