NORTH CENTRAL NEUROLOGY ASSOCIATES, P.C.

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RELEASE OF INFORMATION CONSENT FORM

I ______________________________ (name of patient),

DOB ______________________________ Do authorize/request

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To disclose:
( ) All records
( ) NCV/EMG reports
( ) Lab Work
( ) MRI/EEG reports
( ) CD of MRI/CT/Angiogram

For ongoing care or ______________________________

To: North Central Neurology Associates, P.C. Or ____________________
1809 Kress Street
Cullman, AL 35058 ____________________
Phone 256-739-1210
Fax 256-734-9540 ____________________

Date: ______________________________

Signature of Patient ______________________________

Signature of Parent/guardian ______________________________

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon 6 months or ________________.

Witness: ______________________________ **Date:** ____________________

Notice to accompany disclosure: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as ortherwise permited by 42 CFR part 2. A general authorization for the release of medical records or other medical information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.