

NORTH CENTRAL NEUROLOGY ASSOCIATES, P.C.

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**1809 Kress Street
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Phone: (256) 739-1210
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RELEASE OF INFORMATION CONSENT FORM

I _____ (name of patient),

DOB _____/_____/_____ Do authorize/request

_____ Ph) _____ Fax) _____

To disclose:

- | | |
|--|---|
| <input type="checkbox"/> All records | <input type="checkbox"/> Recent Medical Records |
| <input type="checkbox"/> NCV/EMG reports | <input type="checkbox"/> Admission / Discharge Summary |
| <input type="checkbox"/> Lab Work | <input type="checkbox"/> Recent Hospitalization Records |
| <input type="checkbox"/> MRI/CT/EEG reports | <input type="checkbox"/> Recent ER Records |
| <input type="checkbox"/> CD Disc 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 otherwise permitted 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.