Rex Neurosurgery & Spine Specialists

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I AUTHORIZE

Rex Neurosurgery & Spine Specialists
4207 Lake Boone Trail, Suite 220
Raleigh, North Carolina 27607
Phone: (919) 784-1410
Fax: (919) 784-1409

TO RELEASE THE MEDICAL RECORD OF: (Patient please complete this information)

Name:_____ Date of Birth:____/____/____

Address:_____ SSN: _____-_____-_____

City:_____ State:_____ ZIP:_____

Tele: (____)-_____-_____ Alternate phone: ( ) - _____-_____

Treatment Dates: From:_____ To: _____

THE MEDICAL RECORD MAY BE RELEASED TO:

Name: _____Facility_____
Address: _____City_____State:_____Zip_____
Phone: _____Fax:_____

Office will complete this section
MR#: _____

Information to be released (Check information required):

	X-ray Reports - DVD		Progress Notes		Nurse Notes		Clinic Notes
	Lab reports		Operative Reports		Discharge Summary		Doctor Consults
	EKG, EEG, EMG		Pathology Reports		Emergency Room		Other
	History & Physical		Physician Orders		Urgent Care		

Patient initials only necessary, if permission to release records pertains to the information below
I acknowledge that the data to be released **MAY INCLUDE** material that is protected by law. My **initials** in the boxes below authorize the release (if applicable) of information pertaining to:

	Mental Health		Drugs & Alcohol		HIV/AIDS & other communicable diseases		Genetic Testing

Office will complete this section
Please identify the purpose of this request:

	Continued Patient Care		Soc.Service / Disability		Other:

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Rex Neurosurgery & Spine Specialists

	Insurance		Attorney / Legal		
	Worker's Compensation		Personal		

I understand that:

- I may revoke this authorization at any time
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

I understand that:

- If I revoke this authorization, I must do so in writing.
- The procedure for revoking this authorization is to present my written revocation to the Health Information Management Department at Rex Hospital.

I also understand that:

- I may refuse to sign this authorization.
- Rex Vascular Surgical Specialists LLC will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) upon receiving my signature on this authorization.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire automatically ninety (90) days from the date of signature.

_____ **OR** _____ _____

Signature of Patient | Authorized Representative | Date

_____ _____

Witness | Date

Please explain the Representative's authority to act on behalf of the patient:

_____

Office use only

Date Completed: _____ Completed By: _____

Total Pages: _____ Sent Via: Mail Courier Certified Mail Fax Picked-Up

Fax Number: _____ ❑ Fax Verified ❑ I.D. Checked: _____

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