AUTHORIZATION FOR RELEASE OF INFORMATION

Neurology Associates, Inc.
1034 S. Brentwood Blvd., Ste 754, St. Louis, MO 63117
ph: (314) 725-2010
fax: (314) 725-0709
(Please print all information)

______________________________ ______________________________
Patient Name Maiden/Other Name

______________________________ ______________________________
Birthdate Social Security #

____
Account # (office use only)

The information may be released to the following:

1. Name and address to whom the information is to be disclosed

______________________________ ______________________________
Name of Individual/Agency/Institution Phone Number

____
Street Suite # City State Zip

2. Reason for release: ____

3. Dates of Treatment: ____________________ to __________________

4. Description of Information Requested:
Check all that apply)
_____ Office Notes
_____ Radiology Reports
_____ Laboratory Reports
_____ Procedure Reports (NCV/EMG, Lumbar Puncture)
_____ Other (Please Specify) ____

5. Special Release: I hereby authorize the release of documents relating to:
(Circle 'N/A' if not applicable)
Y N N/A Psychiatric Treatment
Y N N/A Drug and/or Alcohol Abuse
Y N N/A HIV/AIDS Testing and/or Treatment

- **I hereby authorize Neurology Associates, Inc. to release information from my medical record as I have indicated in sections 4 and 5 above.**
- **I understand that only those records which originated at Neurology Associates, Inc. will be released. Records originating at other locations including hospitals, labs, or other doctors' offices require authorization from the originator.**
- **I understand that once my medical information is released pursuant to this authorization, it may be disclosed by the recipient and no longer be protected by federal or state law.**
- **I understand that I have the right to revoke this authorization, in writing, at any time by notifying the Privacy Officer of Neurology Associates, Inc. I understand that a revocation is only effective to the extent that Neurology Associates, Inc. has not already relied on this authorization to use or disclose my health information.**
- **Neurology Associates, Inc. will not condition my treatment on whether I sign this authorization.**
- **Unless other event is specified below, authorization is valid for six (6) months from the date of signature.**
EVENT:____

______________________________ ______________________________
Signature of patient/legal representative Date Signed

______________________________ ______________________________
Relationship to patient if not signed by patient Neurology Associates Employee authorizing disclosure

A copy of this authorization is as valid as the original.