AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____

Entity/Person **from** whom records are requested; Include full name

_____

Complete address,

_____

City, State, ZIP, Telephone and Fax.

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name _____

Date of Birth ☐☐/☐☐/☐☐☐☐ (MM MM DD DD YY YY YY YY) Social Security Number ☐☐☐-☐☐-☐☐☐☐

Patient Address _____ Phone Number (___) ____ - _____

Date(s) of Service (if known) _____

Description of information to be released: (Check ✓ all that apply)

____ Emergency Room	__x_ Radiology Reports	____ Admission / Registration	____ Other: _____
____ History & Physical	____ Consultation Reports	Records	_____
____ Nurse's Notes	____ Physician's Orders	__x_ Laboratory Reports	_____
____ Progress Notes	__x_ Operative Records	____ Billing Records	_____
____ Discharge Summary	__x_ Radiology Films		

Description of the purpose of the use and / or disclosure:_____

_____

The health information described herein shall be released to: (Check ✓ the appropriate category)

___Hospital __Physician ___ Insurance Company ___ Attorney ___ Patient ___ Other

(Check ✓ the appropriate delivery method)

Name __Karen Fink, M.D., Ph.D_____ Mail _____ Fax _____

Address __3600 Gaston Ave., Barnett Tower #605, Dallas,TX 75246_____ Pick-up Records _____

Phone Number ___214.820.8690____ Fax Number___214.820.8691_____ Other _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_ No Expiration___ (Expiration date / event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative

PATIENT IDENTIFICATION NO. _____

PATIENT _____

PHYSICIAN _____

NEURO-ONCOLOGY ASSOCIATES
3600 Gaston Avenue, Barnett 605
Dallas, TX 75246

AUTHORIZATION FOR RELEASE OF INFORMATION (Rev. 9/04)