VERO BEACH NEUROLOGY & Research Institute

Authorization For Release Of Medical Record Information

Patient Name: _____ Date of Birth: _____

Phone(C): _____ Phone (H): _____

Address: _____ City/State/Zip: _____

I Authorize to Release My Medical Records to:

Doctor/Facility Name: _____ Address:_____

PH: _____ FX:_____

Please Release the Following:

[ ] Office Visits [ ] Radiology Reports Only
[ ] In-House Testing [ ] Lab Work

[ ] Additional:_____

RESTRICTIONS: Only medical records originated, and ordered by Dr. S. James Shafer and Stacy Smith PA-C will be Released. This authorization is valid only for the release of medical information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or Human Immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. This information may be disclosed and used by following individual or organization: I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with tit the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact VBNRI making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature: _____ **Date**: _____

Name of authorized Representative: _____ Relationship:_____