

**TIDEWATER NEUROLOGISTS, INC.**  
**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Fax To: \_\_\_\_\_

\_\_\_\_\_  
(PRINT Patient's full name)

\_\_\_\_\_  
(Date of BIRTH)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(Phone Number)

I, \_\_\_\_\_ do hereby authorize TIDEWATER NEUROLOGY to release:

**DATES OF:** \_\_\_\_\_

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> EMERGENCY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> ALL RECORDS
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> EKG/EEG/CARDIC CATH	_____

I do  I do NOT: authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**INFORMATION RELEASE TO:** \_\_\_\_\_

Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**PURPOSE OF DISCLOSURE:**

<input type="checkbox"/> REFERRAL TO SPECIALIST	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> WORKERS COMP
<input type="checkbox"/> CHANGE OF DOCTORS	<input type="checkbox"/> LEGAL INVESTIGATION	<input type="checkbox"/> DISABILITY DETERMINATION
<input type="checkbox"/> PERSONAL	<input type="checkbox"/> OTHER (SPECIFY) _____	

**Please provide current telephone number in the event we need to contact you:** \_\_\_\_\_.

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me or whether or not I sign the authorization.

\_\_\_\_\_  
**Signature of Individual or Guardian or Personal Representative of Patient's Estate**

\_\_\_\_\_  
**Date**

**NOTE:** There will be a **charge** for a personal copy or permanent transfer of your records. Our fee is \$10.00 plus .50 per page of all records copied. This fee covers the cost of materials and staff time.