North Shore Neurology & EMG, LLC

Women's Health and Medical Arts Building
83 Herrick St. Ste 1001 • Beverly, MA 01915-1777 • 978-922-2226

I authorize North Shore Neurology & EMG to release and/or obtain protected health information from the medical records of:

____ _____/_____/______ ____________________

Last Name First Name MI Date of Birth Social Security Number

For the purpose of: ☐ Continuing of Care ☐ Other (Please Specify) ___________________________

To: ____

Type of information to be disclosed: (Please check below and unless specified, most recent date will be released)

______History and Physical
______Discharge Summary
______Consultation Reports
______Operative Reports
______Laboratory Reports
______Imaging (i.e. X-Rays, CT Scans)
______Other, please describe: ____
______Emergency Reports
______Progress Notes
______Orders
______PT/OT, Respiratory, Dietary Notes
______Nursing Notes and Forms
______Medication Record

I understand that the information in my medical record may include information relating to sexually transmitted disease, AIDS, and/or HIV. It may also include information about behavioral or mental health services and/or alcohol and drug abuse treatment. I agree to its release:

______ YES ______NO Sexually Transmitted Disease
______ YES ______NO Psychiatric/Psychological Information
______ YES ______NO Substance Abuse/Treatment (Drug/Alcohol)
______ YES ______NO HIV/AIDS Information

(*Must obtain authorization for each requested release of results of HIV/AIDS information)

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 copy the information to be used or disclosed, as provided by CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-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 the Privacy Officer or Director of Patient Relations.

I understand that I have a right to 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 that 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. Unless otherwise revoked, this authorization will expire one year from the date of signature.

____

Signature of Patient/Legal Representative Date Relationship, if other then patient
(Attached legal documents when applicable)

____

Signature of Witness Date