NORTHEAST REGIONAL EPILEPSY GROUP

Patient Authorization to Disclose Health Information

Patient Name (Please Print) _____Date of Birth: _____

I authorize the use or disclosure of my health information to be released **TO** Northeast Regional Epilepsy Group.

From:

Doctor/Hospital/Medical Group: _____

Address: _____

_____

Phone: _____ Fax: _____

I authorize the following health information to be released from above doctor, hospital or facility.

( ) Entire Chart

( ) Specific records from _____ to _____

( ) Radiology (x-ray, ultrasound, CT, MRI etc.)

( ) Labs ( ) other _____

I understand that these records are protected under Federal and/ or State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and or/ mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

_____ _____

(Signature of Patient or Legal Guardian) (Date)

_____

(If Guardian Relationship to Patient)

Please mail records to NEREG: