Advanced Neurology, LLC

Mahmood G Alnahass, MD

1551 S Sturdy Rd, Valparaiso, IN 46383

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name _____

Patient Date of Birth _____ Patient Phone #_____

Address _____

City / State / ZIP _____

I hereby authorize the protected health information regarding the above-named person be forwarded:

Doctor/Institution_____

Address _____

City/State/Zip _____

Phone _____ Fax_____

TO: Dr. Mahmood Alnahass, MD
Advanced Neurology
1551 South Sturdy Road
Valparaiso, IN 46383

The type of information to be used or disclosed is as follows:

- ☐ Past 6 months of labs
- ☐ Past 6 months of Consultation report/Progress notes/doctor notes
- ☐ Past 6 months Neurological tests/Diagnostic tests
- ☐ Other _____
- ☐ Botox amount _____ Site_____

This information for which I'm authorizing disclosure will be used for the following purpose:

sharing with other health care providers for _____continued care or _____transfer of care.
other (please specify) _____.

I understand that:

- Unless revoked, this authorization will expire 60 days from the date of signature on the authorization or from the date noted above. (For mental health purposes this authorization will expire one year from the date of signature).
- I understand authorizing the use or disclose of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the authorization, in which case Advanced Neurology may refuse to treat me if I do not sign this Authorization.
- Once Advanced Neurology discloses my health information to the recipient, Advanced Neurology cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I have the 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 Advanced Neurology. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand 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.
- I may be charged a reasonable fee for obtaining the records requested in this authorization. This fee includes the copying expenses of copying the records & postage if the records are being mailed.
- This release might include medical records of treatment for physical and/or emotional illness, including alcohol/drug diagnosis, treatment and/or referral information, personal/social information. HIV/AIDS related health information and/or records might also be released.

I have read and understand the terms of the Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Advanced Neurology to use or disclose my health information in the manner described above.

_____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

_____ (PRINTED NAME)