Metrolina Neurological Associates, PA

Acknowledgement of Receipt of Notice of Privacy Practices

_____ _____

Patient Name Date of Birth

I have received a copy of the Notice of Privacy Practices for the above practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time
- ❑ The individual refused to sign
- ❑ A copy was mailed with a request for a signature by return mail
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other: _____

Prepared by_____

Signature_____

Date_____

Authorization for Release of Information

Name of Patient _____ Date of Birth_____

Metrolina Neurological Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. To receive copies of the patient's medical records, a release of information will have to be signed by the patient or health care power of attorney.

Entity to Receive Information- Check each person/entity that you approve to receive information. Please list the full name of the person you are authorizing to receive information	**Description of Information to be Released -**Check each that can be given to person/entity on the left in the same section
❑ Home voicemail _____ ❑ Cell voicemail _____ ❑ Email	❑ Results of labs, tests/x-rays ❑ Appointment ❑ Financial ❑ Medical as follows_____
❑ Spouse _____	❑ Results of labs, tests/x-rays ❑ Appointment ❑ Financial ❑ Medical as follows_____
❑Parent(s) _____ _____	❑ Results of labs, tests/x-rays ❑ Appointment ❑ Financial ❑ Medical as follows_____
❑Children _____ _____	❑ Results of labs, tests/x-rays ❑ Appointment ❑ Financial ❑ Medical as follows_____
❑Other _____ _____	❑ Results of labs, tests/x-rays ❑ Appointment ❑ Financial ❑ Medical as follows_____

Patient Information

I understand that I have the right to revoke this authorization at any time by contacting our office and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>This authorization shall be in effect until revoked by the patient.</u>

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation: _____