PACIFIC NEUROSCIENCE MEDICAL GROUP

Authorization to Release Personal Health Information (PHI)
from Pacific Neuroscience Medical Group to New Neurologist

I authorize the release of my PHI, as described below, to my new neurologist by ☐ fax ☐ mail:

Name of neurologist ______________________________
Address ______________________________
Phone ______________ Fax ______________

☐ Please provide me with a copy of the same information by ☐ fax ☐ mail ☐ OnPatient
☐ I do not need a copy of my personal health information at this time.

My name: ______________________________
Address: ______________________________
Phone: ______________ Fax: ______________
E-mail: ______________ SSN: ______________

PHI to be released

Full medical record, consisting of any and all personal health information in the possession of or known by the staff or employees of Pacific Neuroscience Medical Group at this time, including but not limited to medical, neurological, psychiatric, psychological, neuropsychological diagnoses; medications; medical, family, social history including possible past or present use or misuse of controlled substances; progress notes; test reports; medical decision-making, administrative notes; other.

Purpose for release of PHI

Continuity of care.

Please initial below

______ I understand that this authorization is voluntary.

______ I understand if any entity I have authorized to receive information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

______ I understand I have the right to receive a copy of this authorization.

Fees

If sent through OnPatient:	No charge
If faxed:	10 cents per page.
Printed paper copies:	25 cents per page plus $25 for shipping and handling.

Authorization

I authorize the release of my PHI as described above. This authorization will expire on: ______________ (insert date or write "never" if you do not want this authorization to expire).

______________________________ ______________________________ ______________
Patient or Power of Attorney (name) Signature Date