Josephson Wallack Munshower Neurology PC

Comprehensive Neurological Expertise
Compassionate Patient Care

AUTHORIZATION TO DISCLOSE/OBTAIN MEDICAL INFORMATION

Return to : PatientInfo@jwmneuro.com

I, _____, hereby authorize **Josephson-Wallack-Munshower Neurology, PC** to disclose/obtain the following identified health information.

Patient Name: _____

Address: _____

City, State, & Zip: _____

Phone: _____ Date of Birth: _____

The Information is to be released to:

_____

Mailing Address: _____

_____

Phone Number _____Fax Number_____

I authorize release of the information described below:

- **All Records**
- **Office Visit Notes**
- **Itemized Billing**
- **Prescriptions**
- **History & Physical**
- **Labs**
- **Specific information/Dates:** _____
- **Other**

Reason for this request/disclosure_____

I understand that the Protected Health Information in my medical record may include information relating to Dangerous Communicable Diseases including acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Limitations: Do not release information in my records regarding:

I understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken in reliance on the authorization. Otherwise, this consent will be considered valid for a sixty (60) day period as specified in I.C. 16-39-1-1. A consent to release Psychiatric/Mental Health records as valid for a sixty (60) day period.
I further agree to pay Josephson-Wallack-Munshower Neurology, PC the actual cost incurred by the office in preparing the copy of the requested information should I choose to receive these records directly.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I am responsible for all fees associated with releasing my health information. I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

Legal signature of requestor _____ **Date** _____

Relationship to patient, if other _____