New Way Neurology
AMERICAN ONCOLOGY PARTNERS

Authorization For Release of Patient-Identifiable Health Information

(If under 18 years of age, parent or guardian must sign)

PATIENT IDENTIFICATION:	**Patient ID#:**	**Date of Service:**
Name:	Date of Birth:	Social Security #:
Address:	City:	State/Zip:
Previous Name:		
New Address:	City:	State/Zip:

I request and authorize the use or disclosure of the above named individual's health information as described below.
New Way Neurology is authorized to make this disclosure.

For the purpose of:

☐Continuation of medical treatment	☐Payment of bill	☐Worker's Comp/Insurance/Claim
☐Personal use	☐Legal or insurance purposes	☐Other *(specify)*
☐Administrative (i.e., FMLA)	☐Patient Request	

The type and amount of information to be disclosed is as follows:

	Dates *(from/to)*		Dates *(from/to)*
☐General - Documents		☐Radiology Reports	
☐Laboratory Reports		☐Images, specify exam(s)/body part(s)	
☐Physician Summary		☐Nurses Notes (MAR)	
☐Treatment Plan		☐Entire Record	
☐Orders		☐Billing	
☐Visit Notes		☐Other (specify)	

_____(initial) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis. It may also include information about genetic information, behavior or mental health services, and treatment for alcohol and drug use.

_____(initial) This information may be disclosed to and used by the following individual or organization:

RELEASE RECORDS TO *(Where records should be sent)*:
☐*Same as above* **OR:**
Name/Agency/Healthcare:_____

_____
Address **City** **State** **Zip**

***Email:**_____ **Fax:**_____
***Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving your records via email to the address you specify.**

INFORMATION REQUESTED: Fees may apply.

_____ (initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original. If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/she should put an "X" on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

I understand that the provision of treatment or payment cannot be conditioned on my signing of this authorization unless otherwise permitted under state and federal law. However, if treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I understand that this release is revocable by me at any time, except to the extent that action has already been taken in reliance to it. The request will become effective upon delivery of the written revocation to the disclosing entity. Unless revoked, this authorization for release of information expires in one year after the date of signature.

_____ _____
Signature of Patient/Legal Representative Date

Relationship to Patient:_____

Release - EFFECTIVE 9-07
Revised: 08-16-2012; 10 09 2014; 06 26 2017; 12 01 2020; 09 01 2021

I AM ENTITLED TO A COPY OF THIS AUTHORIZATION