NEUROCAREPLUS
DR. NICOLAS NAMMOUR
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PH: 281-579-6800 / FAX: PH: 281-579-6804

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Ph: _____
Date of Request: _____ Date Needed: _____

I authorize NeuroCarePlus *to* ***release*** information **to:**

_____
Name of Provider or Facility

_____
Address

_____
City, Address, Zip Code

_____
Phone / Fax # (include area code)

OR

I authorize NeuroCarePlus to ***request*** information **from:**

_____
Name of Provider or Facility

_____
Address

_____
City, Address, Zip Code

_____
Phone / Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one)

☐ Healthcare ☐ Personal ☐ Transfer of Care ☐ Other: _____
(Please describe)

TYPE OF RECORDS REQUESTED: (Check one)

☐ All medical records related to a specific illness or injury

_____
Specify illness/ injury Date of treatment

☐ Treatment summary (progress notes, laboratory tests & radiology reports, operative reports, pathology)
☐ Specific information (Select one or more, as applicable)

☐ Procedure Report ☐ Physical Therapy ☐ Laboratory Tests ☐ Radiology Reports ☐ Other : _____
(Please describe)

☐ Copy of the entire medical record, as allowed by law.

I UNDERSTAND THAT:

- My right to health care treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, **the information stated above could be re-disclosed.**
- Release of HIV- related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only. Please use black or ink type only.

Signature of Patient or Representative _____ Date: _____
Name and relationship to Patient (if requester is not the patient) _____