NEUROLOGICAL SURGERY, P.C.
100 Merrick Road, Suite 128W – Rockville Centre, NY 11570
Phone (516) 255-9031 Fax (516) 255-6010

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth

I, or my authorized representative, request that health information regarding my care and treatment be released by **Neurological Surgery, P.C.** as set forth on this form.

In accordance with applicable law, I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line below. In the event the health information described below includes any of these types of information, and I initial the line on the box below, I specifically authorize release of such information to the person(s) indicated below.
2. If I am authorizing the release of HIV-related, substance abuse, or mental health treatment information, the recipient is prohibited from disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the NYS Division of Human Rights at (212) 480-2493 which is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to **Neurological Surgery, P.C.** I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be disclosed by the recipient and this disclosure may no longer be protected by federal or state law.

Name and address of person(s) or category of person to whom this information will be sent:	
Specific information to be released: ☐ Entire Medical Record from (insert date) _____ to (insert date) _____ ☐Specific Portions of the Medical Record as follows: _____ ☐ Other: _____	
Include: (*Indicate by Initialing)* _____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ **HIV-Related Information**	
Reason for release of information: ☐ At request of individual ☐ Other:	Date or event on which this authorization will expire:
If not the patient, name of person signing form:	Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Signature of patient or representative authorized by law.	Date: _____

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**