RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE
NEUROLOGY

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this authorization, I authorize Synapse Neurological Care, P.A. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below:

I, _____ , Date of Birth: _____ , SSN:_____

Hereby authorize Synapse Neurological Care, P.A. to ☐ OBTAIN ☐ RELEASE medical information via mail, facsimile, or other appropriate source ☐ TO ☐ FROM:

_____
PERSON(S) OR ENTITY(S) TO RECEIVE / RELEASE REQUESTED INFORMATION

_____
ADDRESS CITY, STATE, ZIP PHONE # FAX #

I. The individually identifiable health information to be obtained / released is *(Please specify)*
- ☐ All Medical Records / Information
- ☐ Entire Medical Chart
- ☐ X-Ray, Lab or other Diagnostic Reports
- ☐ Only the period of Events from _____ to _____ *(dates)*
- ☐ Only information related to *(specify)* _____
- ☐ Other: *(specify)* _____

Additional information to obtain / release
☐ Psychological Records / Information ☐ Drug / Substance Abuse ☐ HIV Results, Information

- *Alcohol, drug abuse information, etc. if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42 CFR part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. Additionally, further release of HIV related information is prohibited without specific authorization.*

II. The Purpose or need for the disclosure of information is
☐ Continued Medical Care ☐ Legal Case ☐ Personal Use ☐ Other *(specify)* _____

III. This authorization will expire on _____ (Please indicate expiration date or specific event).
{If authorization not revoked, and no expiration / event is noted, it will terminate one year from the date of signature below.}

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protect health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must be submitted to Synapse Neurological Care, P.A. Privacy Officer at the address noted on this authorization.

I understand that this practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I further understand that Synapse Neurological Care, P.A. may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPAA privacy rule.

I understand I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release or receipt of the information requested.:

_____ _____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT DATE SIGNED