AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name: ____Date of Birth_________________

Alias/Maiden Name:__________________________________Soc. Sec #___________________

Persons/Organization(s) receiving the information: _____________________________________

____

Specific description of information (includes dates):______________________________________

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Purpose of disclosure: ____

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I understand that this authorization will expire on _______________ (day/mo/year)

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

_____________________________________ ___________________

Signature of patient/patient's representative Date

_____________________________________ _________________________

Printed name of patient's representative Relationship to the patient

FOR ADVENT NEUROLOGY, SC USE ONLY

_______________________________ ___________________

Information Released by Date of Release

Method of release O Phone O Fax O Mail O Electronic O Verbal