RECORD RELEASE AUTHORIZATION

Island Neurological Associates, P.C.

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516-822-2230 FAX# 516-822-0163

I, _____Date of birth_____
PATIENT NAME

Hereby authorize:_____
DOCTOR OR HOSPITAL

_____
ADDRESS

To disclose and release for the purpose of treatment and/or payment to the above named.

My complete history records in your possession, concerning my illness and/or treatment.

I understand that this will include information relating to the release of HIV-related, alcohol or drug treatment, or mental health treatment.

I understand that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

( ) All health records under your care.

( ) specific dates to:_____ from:_____

( ) specific treatment _____

I understand this authorization may be revoked in writing at any time. Unless otherwise revoked, this authorization will expire in 12 months from the date signed. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for the above disclosure of the information to the extent indicated and authorized herein.

I may request a copy of this form in writing.

Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above) and this re-disclosure may no longer be protected by federal or state law.

Patient Name_____SS#_____

Address_____

Signature_____Date_____

7/13/07