Neurology Partners, LLC
76 Park Street
Attleboro MA 02703
Ph 508.431.2026
Fax 508.431.2296

Authorization for Use and Disclosure of Protected Health Care Information:

I, ____ Date of Birth_______________

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization. I authorize Neurology Partners to

Release to: **Request from:**

Name: ____

Address: ____

____

I give permission for any information including the diagnosis and records of any treatment or examination rendered to me during the period of: __________________ to: ____.

I hereby Consent Refuse

To the release of confidential information concerning: Mental Health, Alcohol, and/or Drug Use, Sexual Abuse, Venereal Disease, AIDS, or HIV test results.

This authorization will expire on ________________________. If no date is given, this authorization will expire one year from the date signed at the bottom of this form.

____
Patient signature/or authorized representative Date

____
Printed name of legal representative Relationship

____
Witness Date

There may be a processing fee and copying cost.