

PARKWAY NEUROSCIENCE & SPINE INSTITUTE  
17 WESTERN MARYLAND PARKWAY, SUITE 100  
HAGERSTOWN, MARYLAND 21740  
301-797-9240, OFFICE 301-797-0008, FAX

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
(Print patient's full name)

\_\_\_\_\_  
(Birth date (Mo/Day/Yr))

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(City/State/Zip Code)

\_\_\_\_\_  
(Home Phone)

At the request of the individual, I \_\_\_\_\_,  
(Patient's Name), do hereby authorize to release:

**DATES OF** \_\_\_\_\_

\_\_\_\_ DISCHARGE SUMMARY  
\_\_\_\_ HISTORY & PHYSICAL  
\_\_\_\_ PROGRESS NOTES  
\_\_\_\_ OPERATIVE NOTES

\_\_\_\_ PATHOLOGY REPORTS  
\_\_\_\_ LABORATORY REPORTS  
\_\_\_\_ RADIOLOGY REPROTS  
\_\_\_\_ ECG/EEG/CARDIAC CATH

\_\_\_\_ EMERGENCY REPORTS  
\_\_\_\_ OTHER \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ I do \_\_\_\_ I do NOT

authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**INFORMATION RELEASE TO:**

\_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip Code

**PURPOSE OF DISCLOSURE:**

\_\_\_\_ REFERRAL TO SPECIALIST  
\_\_\_\_ LEGAL INVESTIGATION  
\_\_\_\_ PERSONAL  
OTHER (SPECIFY) \_\_\_\_\_

\_\_\_\_ INSURANCE  
\_\_\_\_ DISABILITY DETERMINATION  
\_\_\_\_ CONTINUING CARE

\_\_\_\_ WORKERS COMP  
\_\_\_\_ CHANGE OF DOCTOR

Please provide current telephone number in the event we need to contact you: \_\_\_\_\_

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
Signature of individual or guardian or  
Personal Representative of patient's estate

\_\_\_\_\_  
Date

**MEDICAL INFORMATION RELEASED BY HEALTHPORT**

ENTIRE \_\_\_\_\_  
DS \_\_\_\_\_  
OP \_\_\_\_\_  
HP \_\_\_\_\_  
NUMBER OF PAGES \_\_\_\_\_

LAB \_\_\_\_\_  
EKG \_\_\_\_\_  
X-RAY \_\_\_\_\_  
PATH \_\_\_\_\_

EKG \_\_\_\_\_  
IMMUNE \_\_\_\_\_  
OTHER \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
ROI SPECIALIST

\_\_\_\_\_  
DATE

HealthPort  
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Atlanta, GA 30384-9822  
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