The Parkway Neuroscience And Spine Institute, LLC

**Options for release**
**Mail Out __**
**Pick-up __**
**Email ___**

**Records requests fax number – 301-797-4234** **Faxing all incoming records – 301-797-0008**

13 Western Maryland Parkway, Suite 20, Hagerstown, MD 21740

## AUTHORIZATION FOR RELEASE OF INFORMATION

**Patient Reference:**
Patient's Name: _____ Birth Date: _____
Address: _____
City/State/Zip Code: _____
Phone # _____ Email Address _____

☐ **Information to be Released To:**

☐ **Name of Other Facility Disclosing Information to Parkway Neuroscience and Spine Institute:**

_____
_____
_____
_____

**Records Involved: Dates:**

__Office Notes _____
__Physical Therapy _____
__Surgery Center _____
__ Other _____

**Purpose of Disclosure**: _____Legal ____Insurance _____ Social Security Disability
___Other - Specify:_____

**Patient Initials _____ SPECIAL AUTHORIZATION**: I understand that my medical records may contain alcohol/drug abuse, Human Immune Virus/Acquired Immune Deficiency Syndrome related and/or mental health information. I give special authorization to the health care facility to release this information in my records to the person or organization named above, for reasons outside of continuity of care

**Patient Initials_____ GENERAL AUTHORIZATION**: I understand and acknowledge that this authorization allows the entity outlined above to release all or part of the records indicated above with the exception of the specially protected health information referred to under the Special Authorization section of this form. I understand that, **on occasion,** general information may be released by telephone or fax. (1) I understand that I may revoke this Authorization at any time, except to the extent that action based on this Authorization has been taken, by sending a letter signed by me to: Parkway Neuroscience and Spine Institute, 17 Western MD Parkway, Hagerstown, MD

(2) The entity outlined above may not condition treatment on my agreement to sign this Authorization.

(3) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipients listed above and may no longer be protected. (4) This Authorization is fully understood by me and is made voluntary on my part.

**Patient's Signature:_____**
**Date Signed:_____**