Neuro Medical Care
ASSOCIATES, PLLC
52 Harrison St, 2nd Floor Johnson City, New York 13790

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Neuro Medical Care Associates, PLLC to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I do not authorize Neuro Medical Care Associates, PLLC to release any or all information concerning my medical care to any individual except as set forth above.

_____I authorize Neuro Medical Care Associates, PLLC to VERBALLY release any or all information concerning my medical care to the following individuals.

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Patient Signature	Today's Date
Print patient name	Date of Birth

_____I authorize Neuro Medical Care Associates, PLLC to release any or all information concerning my medical care to the following referring provider and/or primary care provider.

Name	Address

Phone 607-729-1521 Fax 607-729-7320 www.neuromedical.org
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