Marc Irwin Sharfman, M.D., P.A. / Headache and Neurological Treatment Institute
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AUTHORIZATION TO RELEASE, REQUEST, OR OBTAIN CONFIDENTIAL INFORMATION

By signing this authorization, I authorize Headache and Neurological Treatment Institute to use and/or disclose certain protected health information, (PHI), about me to or for the party or parties listed below.

I, _____, Date of Birth: _____, SSN: _____, hereby authorize Headache and Neurological Treatment Institute to **[ ] OBTAIN [ ] RELEASE** medical information via, mail, facsimile, or other appropriate source **[ ] TO [ ] FROM:**

_____

(Person(s) or Entity(s) to receive/release requested information)

_____

(Address) **(City, State, Zip)** **(Phone number)** **(Fax Number)**

I. The individually identifiable health information to be obtained/released is: (Please place a √ in appropriate space(s)).

____ Dr. Sharfman Office Notes ____ Entire Medical chart (Specify if cover to cover)
____ Massage / Physical Therapy notes ____ Medication List(s) ____ Financial Information
____ X-Ray, Laboratory or other Diagnostic Reports _____
____ Emergency Room Records from_____ (Dates)
____ Inpatient Records from_____ (Dates)
____ Only the Records from _____ to _____ (Dates)
____ Only information related to (Specify) _____
____ Other (Specify) _____

Additional information to obtain/release: (Please place a √ in appropriate space(s)).
_____ Psychological Records / Information _____ Drug / Substance Abuse _____ HIV results, information

- Alcohol, drug abuse information, etc, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. Additionally further release of HIV related information is prohibited without specific authorization.

II. The purpose or need for the disclosure of information: ___ **Continued Medical Care** ___ **Legal Case** ___**Personal Use**
___ **Other, please explain:** _____

III. This authorization will expire on _____ (Please indicate expiration date or specific event).
(If authorization is not revoked and no expiration/event is noted it will terminate1 year from the date of signature below.)

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must be submitted to Headache and Neurological Treatment Institute's Privacy Officer at the address noted on this authorization.

I understand that Headache and Neurological Treatment Institute may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPAA privacy rule.

I understand I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release or receipt of the information requested.

_____ _____ _____
(Signature of Patient or Legal Guardian) (Relationship to Patient) (Date Signed)

For Office Use Only: Authorization fulfilled and information sent By: _____ **on Date:**_____
_____
_____
_____

(Revised 9/13)