The Neurological Care Center of Montgomery, P.C.
1315 Mulberry Street
Montgomery, Alabama 36106
(334) 262-1113 * (334) 262-1119

HIPPA- Medical Information Release

Effective January 1, 2002

Due to **federal privacy guidelines under HIPPA,** we are required to have a medical release information on file for each patient. This authorizes our office to release medical information to family members, caregivers and friends you have designated, about you or your minor children's **HEALTH INFORMATION.** Included would be all health and identifiable information. This authorizes us to share your health information after proper identification, by verbal or written communication, phone, fax mail, or e-mail as needed for your care to only those identifiable below. Powers of attorney would be listed separately.

In order for us to do this, please list names, date of birth and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

I, _____ (patient name or child's name) give my authorization to the following individual(s) listed below to discuss my medical care with you and or your staff on my behalf.

NAMES	**DOB**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

*****PLEASE LIST ANY PHYSICIAN OR MEDICAL OFFICE YOU WOULD LIKE YOUR MEDICAL RECORDS RELEASED TO, PLEASE PLACE DATE AUTHORIZED**********

Any health information you do not wish to be given out please list below.

_____ _____
_____ _____
_____ _____

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed.

_____ I agree that messages may be left on my voicemail/answering machine from your office.
Signature _____ (relationship if minor) _____Date_____

Witness _____ Date _____

DISCLAIMER (Complete if you want no one else to have access to information)
_____I do not want you to discuss my medical care with anyone other than myself.
Signature _____