Pinehurst
Neuropsychology
Brain & Memory Clinic

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____

Date of Birth: ________/________/________ Social Security Number: ____________________

I request and authorize: ____

to release healthcare information for the above-named patient to:

PINEHURST NEUROPSYCHOLOGY
45 Aviemore Drive, Pinehurst, NC 28374
Phone Number (910) 420-8041
Fax Number (910) 420-8071

Information requested for dates of service: ______________________________

This information will be used to assist in my health care at Pinehurst Neuropsychology.

____ Last Clinic Note ____ Last 3 Clinic Notes ____ First Clinic Notes

____ Discharge Summary ____ History and Physical ____ Consult Notes

____ MRI/CT Brain Results ____ EEG Results ____ Sleep Study Results

____ NCV/EMG Results ____ Medication List

____ Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital waft, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

____ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

____ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date: ____________________