UPPER VALLEY NEUROLOGY NEUROSURGERY, PC

106 Hanover Street, Lebanon, NH 03766 Phone: 603.448.0447 Fax: 603.448.0019

Neurology
Donald W. Ayres, M.D.
Board Certified in Neurology
Added Qualification in Clinical Neurophysiology
ASN Certified in Neuroimaging – MRI & CT
Certified Physician Clinical Trial Investigator

Neurosurgery-Emeritus
Richard L. Saunders, M.D.
Board Certified in Neurological Surgery
Added Qualification in Cervical Spine

Neurosurgery
Hulda B. Magnadottir, M.D.
President
Board Certified in Neurological Surgery

Harold J. Pikus, M.D.
Board Certified in Neurological Surgery

Patrick A. Schembri, PA-C
Board Certified by NCCPA

Joseph M. Phillips, M.D., Ph.D.
Board Certified in Neurological Surgery

Alyssa M. Pearl, PA-C
Board Certified by NCCPA

Darrin M. Michalak, PA-C
Board Certified by NCCPA

Administration
Meredith Underhill, MBA, LPN
Practice Manager

PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

MEDICAL RECORDS USE

Name of Patient: _____
Maiden or Previous Name(s): _____
Address: _____
Birth Date: _____ Social Security Number: _____

I. Authorization for Release of Information: The undersigned hereby authorizes _____ to release to the following insurance company, work comp carrier, physician, hospital or attorney:

_____
_____
_____

(name and address of individual or institution) herein referred to as "Recipient", the following medical information relating to the above-named patient: _____(A) Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information which must be specifically authorized in Section III below to be released; OR INSTEAD _____(B) ONLY the following specific information is to be released:

_____
_____

II. Redisclosure: New Hampshire and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my expressed written authorization, as indicated below.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE. Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information will be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

III. Specific Authorization for Release of Information Protected by State or Federal Law: I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health,
and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: (Place "Yes" or "No" in All boxes:)

PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

III. continued

_____ Substance Abuse (Drug or Alcohol) Information from: _____

_____

_____

(Name of agencies, facilities, or individuals)

_____ Mental Health Information from: _____

_____

_____

(Name of agencies, facilities, or individuals)

_____ AIDS-related Information, Diagnosis, and Test Results from: _____

_____

_____

(Names of agencies, facilities, or individuals)

Furthermore, I SPECIFICALLY AUTHORIZE disclosure of this confidential information to all persons referred to in section I above:
In order for the above information to be released, you must sign here AND at the end of this form.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship, if NOT the patient

I understand that I have a right to inspect the disclosed information at any time. This Authorization is effective for twelve (12) months (OR _____ months) after the date it is signed. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper.

A photocopy, or exact reproduction of this signed Authorization shall have the same force and effect as the original.

_____ _____
Signature of Patient or Legal Guardian Date of Signing

_____ _____
Street Address City/State/Zip Code

_____
Relationship if NOT the patient