NEUROLOGY & SLEEP CLINIC PLC.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized or release. This release is not valid if it does not contain the patient's original signature and date signed. A copy of this signed from may be provided to the patient.

Patient Full Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I hereby authorize Burlington Neurology and Sleep Clinic, PLC

[] To Disclose information indicated below to: [] To receive information indicated below from:

_____

Fax: _____

[] All Medical Records

[] Past _____ years of medical records

[] Other: _____

For the purpose of: ___ Changing physicians ___ Workers Comp ___ Consult/2nd Opinion

Other: _____

I understand that this will include information relating to:

[x] AIDS/HIV [x] Behavioral/psychiatric health [x] Alcohol/drug abuse [x] STDs

Affirmation of Release:
I give Burlington Neurology & Sleep Clinic, PLC or the above named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid until it is revoked in writing and that I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. Copies of the records may be obtained with reasonable notice and payment of processing and copying costs. I further understand that if the person or entity that received the above specified information is not a health care provider, health plan or health care clearing house covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORDS UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

_____ _____
Signature of patient/guardian/legal representative Date Signed

_____ _____
Signature of Witness Date Signed