DERRY NEUROLOGICAL ASSOCIATES
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PERMISSION TO DISCUSS MEDICAL HISTORY

(This form is to authorize exchange of information only, and does not replace a Durable Power of Attorney for Healthcare, a separate document which designates an individual to make healthcare decisions for the patient)

Patient Name: _____(print clearly please)
Patient Address:_____
City, State & Zip Code: _____
Patient's DOB: _____/____/_____

I give permission for my medical history to be discussed with the following individuals:

NAME:_____ RELATIONSHIP:_____
PHONE:_____

NAME:_____ RELATIONSHIP:_____
PHONE:_____

Authorization to discuss sensitive information - please circle YES or NO

YES NO Alcohol/Substance abuse
YES NO Psychiatric/Mental illness
YES NO HIV/AIDS

Check all that apply to this authorization:
_____ Physical Examinations
_____ Progress Notes
_____ Medication List
_____ Test Results (MRI/MRA/CT/EMG/EEG/LAB's, etc.)

Dates of care to be discussed: _____

This authorization to discuss medical history includes all information contained in the medical record(s) **unless specifically excluded by written statement contained on this release form.**
This authorization will be considered valid for a period of **one year** from the date the authorization is signed but I may revoke this permission at any time upon my written request.

_____
Date:_____ Signature of Patient

_____ _____
Signature of Parent or Legal Agent Relationship

To the recipient of this authorized information: This information has been disclosed to you from records whose confidentiality is protected by the Federal Law.