*Medical Information Release Form*

*(HIPAA Release Form)*

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth**

***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Child(ren)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to reach me:

 [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: Date:

Express Prior Consent To Contact Consumer by Cell Phone:

You agree, in order for us to service your account or to collect monies you may owe, Neurology Consultants of Montgomery, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Neurology Consultants of Montgomery, P.C., its employees and/or agents may contact me/us as described above.

Patient Signature: Date: