NEUROSURGICAL

ASSOCIATES, P.C.

Authorization to Disclose Protected Health Information

The undersigned authorizes **Neurosurgical Associates, P.C.**

Fax: (804) 282-2131

to release my health information as noted below:

******All sections must be completed in order for request to be processed******

Patient Information

Patient Full Name: ______________________ **Date of Birth:** __________

Patient Address: ______________________ **Other Names?** __________

City: ______________ State: ____ Zip: ______ Phone #: __________

Release Information To (THIS SECTION MUST BE COMPLETED)

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address and name of your designated recipient if electronic delivery is chosen.

Name/Facility: ______________________ **Attention:** __________

Address: ______________________ **Phone:** __________

City: ______________ State: ____ Zip: ______ **Fax #:** __________

<u>Purpose of Request</u>: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:__________

Information to be Released (THIS SECTION MUST BE COMPLETED)

If you fail to specify, 1 year of records will be provided.

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy

Specify Date(s) of Service: ______________

Body Part: ______________

☐ **Other** (please specify):

____

Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at (866) 967-0133

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.
At no time will the cost-based fees exceed VA law (8.01-413)

I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

DELIVERY METHOD	**[ ] Send by Email***	**[ ] Mail Records on CD**	**[ ] Mail Records on Paper**

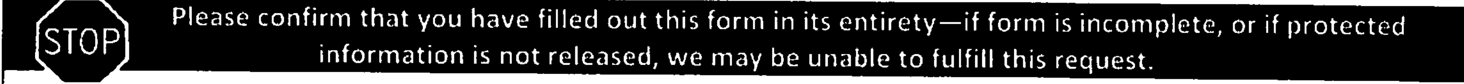
**A valid email must be provided above. If you do not select a delivery method, Sharecare will determine the delivery method based on the information provided on this form.* No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* ________ *(Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ______________. *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.



Signature*: ______________________ **Date:** __________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

NEUROSURGICAL

ASSOCIATES, P.C.

FMLA/DISABILITY AUTHORIZATION

*The undersigned authorizes **Neurosurgical Associates, PC** to release my health information as noted below.*

Phone 804-288-8204 | Fax 804-282-2131

*Patient Information *Please Print**

Patient Full Name: ______________________ **Date of Birth:** __________ **Other Names?** __________

Patient Address: ______________________ **Phone #:** __________ **SS#** (last 4 digits) ______

City: __________ **State:** ____ **Zip:** ______ **Email:** __________

Doctor completing form

Doctor: ______________________ **Chief Complaint:** ______________________

Where do you want the form to be sent after completion?

Purpose of Request: ___ FMLA Leave ___ Short Term Disability ___ Long Term Disability Other: __________

Email address: ______________________

Your record/form(s) will be provided as an Adobe PDF file through our Mail Express portal. If your records/forms are not retrieved within 30 days, they will be deleted. You will receive an email from Sharecare.com containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email.

Name: ______________________ **Attention:** ______________________

Address: ______________________ **Phone:** ______________________

City: __________ **State:** ______ **Zip:** ______ **Fax #:** __________

Information to be Released

___ Please complete the attached form for FMLA/disability leave. I authorize the release of supporting medical records to supplement my leave claim.

___ I am requesting leave starting: ______________
(1st day of Leave)

___ I am requesting intermittent leave.
Reason: ______________
Frequency: ______ times per __ week __ month

FMLA/Disability Forms Completion:
A fee *per form* is due prior to completion of the form(s). The fee schedule is as follows:
$30 for initial form, $15.00 for updates for same qualifying condition.
You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* __________ *(Please Initial)*

I understand that: I may refuse to sign this authorization, and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ______________. *If I do not specify expiration, this authorization will expire in 1 year.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*: ______________________ **Date:** __________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

Dear Patient,

Thank you for contacting **Neurosurgical Associates, PC** Release of Information Department. We are here to serve you and your health information needs.

For FMLA or disability leave paperwork, please complete the enclosed authorization form and attach your blank forms for completion.

- Please make sure you have *specific* instructions included as to where you are requesting the forms to be sent after completion.
- Leave will only be certified based on your treatment plan while under the care of Neurosurgical Associates, PC.
- You may elect to have completed forms emailed, mailed, or faxed to the recipient listed. **It is recommended that you elect to receive your forms back via email.**
- **Please be aware that you are authorizing the release of protected health information to supplement your FMLA/disability leave claim.** This means records may be attached to the forms that are being completed and will be released as indicated on the authorization.

Return the completed release and blank FMLA/Disability forms to:

Fax: 804-282-2131

Mail: **Neurosurgical Associates, PC**
Attn: Medical Records/ROI
1011 Johnston Willis Drive; Suite 100,
North Chesterfield, VA 23235

A fee of $30.00 per form is required prior to form completion. For updates regarding the same qualifying condition and claim, a $15.00 fee will be assessed up to 90 days after initial request. You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider.

Once payment is received, your form will be completed and sent to the recipient listed on your release. For questions pertaining to FMLA or disability leave paperwork, please contact Sharecare Health Data Services at 866-273-4039.

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare Health Data Services
Trusted Partner of Neurosurgical Associates, PC