GHALY

NEUROSURGICAL *associates*
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Authorization For Release of Confidential Health Information

Patient Name: _____

Address: _____

City/state/Zip: _____

Date of Brith: _____

Social Security Number:_____

I hereby authorize that the protected health Information regarding the above-named person be forwarded from:

Name: _____

Address: _____

City/State/Zip: _____

To:

Name: _____

Address: _____

City/State/Zip: _____

Purpose of Authorization: _____

_____

_____

The authorization will include the disclosure of the following records:

- □ Entire medical record, excluding records for the treatment of mental health, alcoholism, drug abuse, HIV/acquired immune deficiency syndrome (AIDS).
- □ Mental health treatment records
- □ Alcoholism treatment records
- □ Drug abuse treatment records
- □ HIV/Acquired Immune Deficiency Syndrome (AIDS) records
- □ Other: _____

For the time period from _____**to** _____**.**