

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** _____.

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