Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

Person requesting information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize CAROLINA NEUROLOGY CENTER to release any

Information necessary for my course of treatment to:

“X” indicates information that may be shared with those specific

PCP\_OR OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ ANY/ALL INFORMATION MAY BE SHARED Initial \_\_\_\_\_\_\_\_\_

□ My spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial \_\_\_\_\_\_\_\_\_

□ Appointment time/date Initial \_\_\_\_\_\_\_\_\_

□ My significant other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial \_\_\_\_\_\_\_\_

□ Medication(s) Initial \_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial \_\_\_\_\_\_\_\_

□ Radiology/Laboratory results Initial \_\_\_\_\_\_\_\_\_

□ Leave a message on my answering machine Initial \_\_\_\_\_\_\_\_\_

□ Procedure/Surgery Information Initial \_\_\_\_\_\_\_\_\_

MEDICAL CONSENT: I consent to the examination treatment and procedures which may be performed during the office visit including emergency treatment considered necessary by the physician. If any invasive procedure is necessary, a specific consent form will be discussed with me at that time.

FINANCIAL POLICY: Payment of deductible or co-payment is expected at the time of service. Cash, check, Master Card and VISA are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company twice after which time responsibility for payment will be yours.

PRINT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_