NEUROSCIENCE
CONSULTANTS, PLC
1830 Town Center Dr, Suite 410 | Reston, VA 20190
Office: 703.478.0440 | Fax: 703.742.9210 | www.nscplc.com
Jon D. Peters, MD

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, the undersigned, authorize Neuroscience Consultants, PLC, 1830 Town Center Dr #410, Reston, VA 20190 to release

health information as noted below:

Please return the COMPLETED authorization to this address or fax to above.

PATIENT INFORMATION:

Patient Full Name: ________________________ Other Names During Treatment? ________________________

Patient Address: ________________________ Date of Birth: ________________________

City: ______________ State: ________ Zip: ________ Phone: ________________________

Email Address: ____

RELEASE INFORMATION TO: (THIS SECTION MUST BE COMPLETED)

Name/Facility: ________________________ Attention: ________________________

Address: ________________________ Phone: ________________________

City: ______________ State: ________ Zip: ________ Fax: ________________________

Purpose of Request: □ Referral by Neuroscience Consultants, PLC to Another Provider □ Second Opinion OR Transfer of Care □ Personal Records

□ Other: ____

INFORMATION TO BE RELEASED:

□ Office Notes □ Labs □ Diagnostic Reports □ Demographic Information □ Entire Chart □ Other: ________________

Specify Dates of Service (If not Entire Chart): ____

□ I DO □ I DO NOT want information about ________________________ released. ________________

Sensitive Information *Patient/Guardian Initial*

- This authorization will expire 1 (one) year from the date below. I understand that I may revoke this authorization at any time by notifying Neuroscience Consultants, PLC. If I do, it will not have any effect on the actions the practice took before it received the revocation.
- I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no long subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Neuroscience Consultants, PLC is in no way conditioned on whether I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.
- I understand that my medical records will be released as indicated above. I understand that I must indicate if there is any sensitive information that I DO NOT want to be released.
- I understand that SHARECARE may MAIL an invoice for records per VA Statutes and payment is made directly to SHARECARE. Questions about my invoice can be answered by calling: (866) 967-0133.

PATIENT NAME: ____ **DATE:** ______________

SIGNATURE OF PATIENT/REPRESENTATIVE: ________________________ **DATE:** ______________