AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Personal Information

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**

Please send my records to

PARS Healthcare Medical Records
C/O Marcela Rugel, M.D.
1212 Garfield Avenue Suite 202
Parkersburg WV, 26101
Phone 304-865-3621
Fax 304-865-3700

Please provide records in CCDA-XML and PDF

Address:			
City:			
State:	**Zip:**	**Phone Number:**	**Fax Number:**

Requesting records from (Please list the facility or institution you wish to obtain your records from)

Description of information to be used or disclosed: ALL RECORDS ☐

OR (Select from the following)

Notes	**Date(s):**	**Diagnostic Reports**	**Date(s):**	**Labs**	**Date(s):**
☐History & Physical ☐Progress Note ☐Discharge Summary ☐ER Notes ☐Consult ☐Other _____		☐MRI ☐MRA ☐CT's ☐XRAYs ☐Echocardiogram ☐EEG ☐Procedures ☐EMG/NCS ☐ Neuropsychological Test ☐Other _____		☐Most Recent ☐B12 ☐CBC ☐CMP ☐Folate ☐TSH ☐Homocysteine ☐Methylmalonic Acid ☐ Other_____	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

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.
4. If the requester 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 redisclosed.
5. I understand that I may request a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I understand that I may inspect and receive a copy of this authorization.
7. This authorization will expire in **one year.**

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Representative:	**Date**
Print Name of Patient or Representative:	**Relationship to Patient:**