

NEURODIAGNOSTIC CONSULTANTS, LLC.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I request and authorize Neurodiagnostic Consultants, LLC. to release health information of the following patient:

Patient Name: _____ Patient Date of Birth: _____

Alias/Maiden Name: _____ Social Security Number: _____

The following health information should be released by mail, phone, fax, electronic transmission or verbally:

_____ Health information pertaining to a specific procedure, test or consultation:
Initials _____

_____ Describe specifically what procedure, test or consultation and provide appropriate dates

_____ HIV/AIDS information. **THIS INFORMATION WILL NOT BE RELEASED UNLESS SPECIFICALLY REQUESTED.**
Initials _____

_____ All health information
Initials _____

Requested health information should be released to: _____

This Authorization expires on _____ when all requested information is released

I understand that this consent may be revoked in writing at any time and that such revocation shall be effective only when it is received by the person otherwise authorized to disclose health information. It is my full understanding that requested health information may contain health information pertaining to evaluation and treatment of mental health problems, disabilities, substance abuse (including alcohol) and that my signature below indicates my consent to and authorization for release of such health information.

Signature of Patient (age 12 and older) Date

Signature of Patient's Parent or Legal Guardian, if applicable Date

FOR NEURODIAGNOSTIC CONSULTANTS, LLC. USE ONLY
Information released by _____, on _____ in the following manner:
 phone fax mail verbally electronic transmission
A copy of this Authorization was provided to the Patient or his/her authorized representative
by _____ on _____.