NORTH CENTRAL NEUROLOGY ASSOCIATES, P.C.

Chris LaGanke, M.D.
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1809 Kress Street
Cullman, AL 35058
Phone: (256) 739-1210
Fax: (256) 734-9540

RELEASE OF INFORMATION CONSENT FORM

I ____ (name of patient),

DOB________/________/______________________ Do authorize/request

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__________________Ph)____________________Fax)__________________

To disclose:

( ) All records
( ) NCV/EMG reports
( ) Lab Work
( ) MRI/CT/EEG reports
( ) CD Disc of MRI/CT/Angiogram
( ) Recent Medical Records
( ) Admission / Discharge Summary
( ) Recent Hospitalization Records
( ) Recent ER Records

For ongoing care or ____

To: North Central Neurology Associates, P.C.
1809 Kress Street
Cullman, AL. 35058
Phone (256)-739-1210
Fax (256)-734-9540

Or: ____________________

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Date: ________________________________

Signature of Patient____

Signature of Parent/guardian____

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon 6 months or ______________.

Witness:____ Date:______________

Notice to accompany disclosure: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as ortherwise permited by 42 CFR part 2. A general authorization for the release of medical records or other medical information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.