*Rockford Neuroscience Center*
*4920 E. State Street*
*Rockford, IL 61108*
*Telephone: 815.226.1906*
*Fax: 815.226.8474*

---

# AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name _____ Date of Birth _____

Address/State/Zip _____

Social Security Number _____ Phone Number _____

**I AUTHORIZE ROCKFORD NEUROSCIENCE CENTER TO DISCLOSE TO:**

Dr. _____

Address/State/Zip _____

I authorize the faxing of my records to the above named party: ☐ Yes ☐ No

**THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD**

Please check the appropriate box(es):

| | | |
|---|---|---|
| ☐ Entire Record | ☐ X-ray Reports | ☐ Hospital Records Only |
| ☐ Lab Reports | ☐ EEG Report | ☐ Clinic Records Only |
| ☐ History and Physical | ☐ EMG Report | |

Approximate dates of treatment _____

Purpose for disclosure (transfer of care, personal use) _____

**NOTICE TO PATIENT**

I understand that this consent is valid for 90 days from the date of signature. I understand that I may revoke this authorization at any time by giving written notice to the Medical Records Department at Rockford Neuroscience Center except to the extent that Medical Records has already acted in reliance on this contract. This authorization will automatically expire when the information requested has been disclosed. I understand that I have a right to review the information being disclosed prior to disclosure if I so request. I understand that I have a right to obtain a copy of the records being released at a charge based on the Medical Records fees in place at the time of disclosure. I understand that my medical records may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also contain information about behavioral or mental health services, developmental disabilities, treatment of drug and/or alcohol abuse, or legal or worker's compensation matters. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of patient or authorized legal guardian_____ Date _____

Relationship to patient, if signed by authorized representative _____

Signature of Witness (if applicable) _____ Date _____