Big Island Comprehensive Neurological Services, Ltd.
Marko Reumann, MD
Fax: 877-992-4535

Authorization for the Use and Disclosure of Protected Health Information

I authorize Big Island Comprehensive Neurological Services, Ltd. (BICNS) to release my Medical Health Information as described below.

Patient Name ____ Birth date ____________________

Address ____ Phone _______________________

City ___________________________ State _____ Zip _________ MR# ______________________

Reason for request: ( ) Continuation of care ( ) Other (explain)______________________

Check off the information you are requesting. Ask a healthcare professional if you need assistance.
BICNS will disclose or release only information created by BICNS.

Date/s of Services __________________

( ) MRI/CT ( ) X-ray ( ) Complete record ( ) Physician office visit record
( ) Laboratory reports ( ) Progress notes ( ) Psychiatric Evaluation ( ) Mental Health records
( ) X-ray ( ) History/physical ( ) ER report ( ) Discharge Summary
( ) Operative Report ( ) Pathology Report ( ) Cardiopulmonary Report

( ) Other: ____________________________________

Please send my BICNS records to:
(BICNS can only FAX records to another provider.)

Name of Medical Facility or Doctor: ____

Phone ___________________ Fax _____________________

Address ____

City ______________________________ State __________ Zip ________________

Patient Rights I understand:

- Signing this authorization is voluntary, and MICNS cannot deny me treatment for not agreeing to sign this authorization. If I refuse to sign the authorization, I understand that BICNS may refuse to provide services a) that are solely for the disclosure to a third party b) that are for a health plan's eligibility or enrollment c) that are research-related and d) that health plans may condition enrollment on a signed authorization.
- I have the right to withdraw this authorization at any time and I must do so in writing addressed to BICNS.
- The information that has already been released in response to this authorization is not affected by my request to withdraw it.
- The withdrawal of this authorization will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- MICNS can no longer protect the confidentiality of information released as a result of this authorization.
- This authorization will expire in six (6) months unless a specific time frame is documented.

I understand that my medical records may contain sensitive information relating to sexually transmitted diseases, HIV, AIDS, genetic testing, psychiatric/mental health treatment and/or testing and treatment for chemical and/or alcohol use.

( ) **I DO** authorize the disclosure of the sensitive information.
( ) I **DO NOT** authorize the disclosure of sensitive information relating to __________________________________

Patient or Legal Representative Signature ____

This authorization is active until ( ) I revoke it in writing ( ) The following date: _______________