

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: _____

Patient's Date of Birth: _____

Patient's SSN: _____ - _____ - _____

PLEASE LIST: Person(s) or Organization(s), and or Family Member(s) authorized to receive the information:

Referring Physicians : _____

Family Members / Care Taker: _____

- 1) I understand that this authorization will expire **one year** from the date signed below.
- 2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying **Neurology Consultants of Dallas** in writing.
- 3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
- 4) I may **inspect or copy** any information used or disclosed under this agreement.
- 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

I have been provided with a Notice of Privacy Practices that provides a more complete description of uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior implementation will mail a cope of any revised notice to the address I have provided.

This consent is given freely with the understanding that:

1. Any and all record, whether written or oral in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

X

Patient's Signature or Patient's Representative

Date