NEUROLOGIC ASSOCIATES, PLC

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name ______________________________________ DOB________________

I Authorize (name and address of *provider*)

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To use and/or disclose my health information to (name and address of *recipient*)

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For the Purpose of: ____

I specifically authorize the following health information and/or records:

____________ Entire medical record

____________ Laboratory reports (specific dates & type if applicable)

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____________ All hospital records to include nurses and progress notes (specify date(s) if applicable) ____

____________ Other (include dates if necessary)______________________________

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I understand that the information in my health record may include information relating to HIV/AIDS or sexually transmitted disease. It may also contain information about behavioral or mental health services and treatment for drug and alcohol abuse.

I understand that I have the right to revoke this authorization at any time in writing. I further understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will remain in effect unless otherwise revoked, as noted above:

I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to ensure treatment. I understand that I may inspect a copy of the information to be disclosed. I understand that any disclosure of information carries with it the potential to be redisclosed and will no longer be protected by federal privacy/confidentiality rules.

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Signature and Date of patient or legal representative

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Relationship of Legal Representative of patient