NEUROLOGICAL SPECIALTIES

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. A brief, non-specific message may be left on your answering machine, or an appointment reminder card may be mailed to the address on file.

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Neurological Specialties? ____ **Yes** ____ **No**

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the Notice of Privacy Practices and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. You have the right to request restrictions on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:
Persons Authorized to receive information from Neurological Specialties:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

____ I do not authorize my information to be released to any other parties except to me as the patient.
____ I do not wish to place any restrictions on the release of information.

This authorization is effective until revoked or terminated by the patient or the patient's personal representative.

You may revoke or terminate this authorization by submitting a written revocation to Neurological Specialties. You should contact the Practice Administrator or other authorized representative to terminate this authorization.

Potential for Re-disclosure: The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

I acknowledge that the HIPAA Notice of Privacy is posted in the Neurological Specialties office. I am aware that I may request a copy if I wish. I understand Neurological Specialties is required to protect my medical information pursuant to HIPAA Privacy Practices.

Signature: _____ **Date:** _____
(Patient or Patient Representative)

Printed Name: _____