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HIPAA Privacy Authorization Form

Authorization for Use and Disclosure of Protected Health Information

Note: This is not a release of medical records

PATIENT NAME: _____ **Birthdate:** _____
(PLEASE PRINT)

If you would like our providers and staff to be allowed to disclose or receive your (or your child's) health information to/from family members, the other parent, or personal representatives please provide the name(s) of the individual(s) here and sign below:

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

PLEASE NOTE:

- Center for Neuroscience will not base treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed.
- You may change or revoke this request by sending a written request to Center for Neurosciences at the address above, ATTN: HIPAA Officer.
- Information disclosed based on this authorization may be subject re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I have read and understand the above information. My signature authorizes the disclosure of the information described. This Release will expire two years from the date of this signature.

Note: All information must be provided – incomplete forms cannot be processed

Name: _____ Patient, *Personal Representative or Parent/Guardian (PLEASE PRINT) _____ Signature _____ Date _____

Relationship if the person signing is other than the Patient: _____

***If this request is made by a Personal Representative, we will require verification of the authority of that Personal Representative before this request will be considered complete.**

Office Use Only
Processed by: _____