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Patient Disclosure Form

I, (patient name) _____

Date of Birth: _____ Address: _____

hereby authorize: _____ to use the following protected health information and/or disclose the following health information to: _____

Name of organization: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

The following information may be used or disclosed:

- Office Records History/Physical Discharge Summary Tests/Xrays Consultation Report
- Lab Report ER Report OR Report In-patient Out-patient
- Other:

Treatment Dates: from _____ to _____

This protected health information is to be used and/or disclosed for the following purposes:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Neurology Indiana LLC. I understand that a revocation is not effective to the extent that Neurology Indiana LLC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Neurology Indiana LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority _____ Date _____