

PATIENT FOCUSED NEUROLOGY

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

II. The information is to be disclosed by:	and is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY PATIENT FOCUSED NEUROLOGY (HENRY TANG, DO - OMID RABBANI, MD - JEFF MORA, MD)
ADDRESS	ADDRESS 2650 JONES WAY #30
CITY/STATE/ZIP	CITY/STATE/ZIP SIMI VALLEY, CA 93065
PHONE:	PHONE: (805) 579-9999
FAX:	FAX: (805) 579-9900
EMAIL:	EMAIL: office@PFneurology.com

III. The purpose or need for this disclosure is:

- Further Medical Care Attorney School Research
 Personal Use Insurance Disability Other (specify) _____

IV. The information to be disclosed from my health record: (check appropriate box(es))

- Entire Record
 Only information related to (specify) _____
 Only the period of event from _____ to _____
 Other (specify) (CHS, Billing, etc.) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment
 Sexually Transmitted Diseases Mental Health (Other than Psychotherapy Notes)
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. _____ (specify new date)

Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

NAME OF PATIENT (Last, First, MI)	D.O.B.
ADDRESS	CITY STATE ZIP
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE