PATIENT FOCUSED NEUROLOGY

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. 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, Ramachandra Tata, MD)**
ADDRESS	ADDRESS **2650 JONES WAY #30**
CITY/STATE/ZIP	CITY/STATE/ZIP **SIMI VALLEY, CA 93065**
PHONE: FAX: EMAIL:	PHONE: **(805) 579-9999** FAX: **(805) 579-9900** 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.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	