NEUROLOGY EAST
48 MEDICAL PARK E DR SUITE 351
BIRMINGHAM, AL 35235
205-836-9366 205-836-9367 FAX

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:_____ DOB:_____

ADDRESS:_____CITY:_____AL:_____

PHONE NUMBER:_____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

ALL: INFORMATION I UNDERSTAND THAT THE INFORMATION MAY CONTAIN PSYCHIATRIC/PSYCHOLOGICAL, ALCOHOL/DRUG ABUSE,AIDS/HIV INFORMATION, AND/OR OTHER SENSITIVE HEALTH INFORMATION AND I EXPRESSLEY CONSENT TO THE RELEASE OF THE INFORMATION.

OR

ONLY THE FOLLOWING RECORDS OR TYPES OF INFORMATION: _____

_____

THE INFORMATION MAY BE RELEASED RELEASED AT FOLLOWS:

FROM: PERSON/ORGANIZATION PROVIDING THE INFORMATION:_____

TO: PERSON/ORGANIZATION RECEIVING THE INFORMATION: NEUROLOGY EAST, 48 MEDICAL PARK EAST DR., SUITE 351, BIRMINGHAM, AL 35235 OFFICE# 205-836-9366 FAX# 205-836-9367

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I UNDERSTAND THE INFORMATION RELEASED WILL BE LIMITED TO INFORMATION TO FULFILL THE NEED OR PURPOSE FOR THE DISCLOSURE. IF I HAVE AUTHORIZED THE DISCLOSURE OF INFORMATION TO THE RECIPIENT WHO IS NOT SUBJECT THE HIPAA OF 1996 THEN THE RECIPIENT MAY RE-DISCLOSE IT ANDIT MAY NO LONGER BE PROTECTED UNDER HIPPA. THIS AUTHORIZATION IS VALID FOR 90DAYS FROM SIGNATURE. THIS AUTHORIZATION ONLY APPLIES TO THE TREATMENT OCCURING BEFORE THE DATE OF SIGNATURE. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. IF I REVOKE THIS AUTHORIZATION IT DOES NOT APPLY TO ANY INFORMATION THAT HAS ALREADY BEEN RELEASED? I UNDERSTAND THAT THEY MAY BE CHARGE FOR MEDICAL RECORDS BEING RELEASED. I REPRESENT THAT I HAVE THE AUTHORITY TO AND VOLUNTARILY GRANT PERMISSION FOR THE INFORMATION TO BE RELEASED AS DESCRIBED ABOVE.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTIVE DATE

_____ _____

WITNESS DATE