AUTHORIZATION TO VERBALLY RELEASE PROTECTED HEALTH INFORMATION

I,_____ hereby authorize PIERCEY NEUROLOGY LLC to verbally share confidential information to the following individuals:

Name:_____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Concerning: (Check One)

☐ Appointment Dates / Times Only

☐ <u>All matters</u> relating to my health care including mental health, alcohol, drug treatment, and communicable diseases.

OR

☐ Only specific health care problems and treatment relating to: _____

_____

(Describe the conditions for which information may be released)

This authorization may be revoked at any time by notifying PIERCEY NEUROLOGY LLC in writing, but the revocation will not affect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire upon my written request for change or revocation, directed to PIERCEY NEUROLOGY LLC.

I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations.

_____	_____	_____
Patient's Signature	Date of Birth	Today's Date