AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I,_____, authorize my medical records be disclosed,

FROM: _____

_____

_____

CONSISTING OF: ☐ Last Two Years ☐ Entire Record ☐ Specific: _____

_____

TO: _____

_____

_____

FOR THE PURPOSE OF: ☐ Self Use ☐ Legal/Disability ☐ Changing Doctors ☐ Moving/Relocating
☐ Referral/Consultation ☐ Continuity of Care/Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

☐ HIV/AIDS information
☐ Mental-health information (including memory tests)
☐ Genetic testing information
☐ Sexually transmitted disease information
☐ Alcohol/chemical dependency diagnosis, treatment or referral information

PATIENT INFORMATION I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services ore reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization will also not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in a health plan. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Piercey Neurology or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

Unless revoked, this authorization expires one year from the date signed below. I understand that I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with my permission cannot be undone.

SIGNATURE: By signing below, you agree that you have read this authorization and understand it.

Signature:_____ **Today's Date:** _____ **DOB:** _____
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority:_____