

NEURO INSTITUTE
AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Full Name: _____ Date of Birth: ___/___/___

Date of Authorization: ___/___/___

I authorize Neuro Institute to:

RELEASE or **RECEIVE AND USE** my protected health information (medical records).

TO/FROM: Name: _____
Address: _____
City/State/Zip: _____
Phone: (____) _____ Fax: (____) _____

TO/FROM: Neuro Institute
1221 West Warner Road, Suite 102
Tempe, Arizona 85284
(480)735-0124; (480)735-0126 Facsimile

Please indicate which records you are requesting (please check and/or give dates):

_____ Complete copy of medical records (includes information regarding: alcohol and/or drug abuse, HIV/AIDS, behavioral health/psychiatric assessment and/or treatment including psychotherapy notes, and communicable diseases.

_____ Complete copy of medical records with billing dates.

_____ Medical Doctor Evaluation/Admission & Discharge Summaries

_____ PT/OT/ST Evaluation & Discharge Summaries

_____ EMG/NCV Reports

_____ Modified Barium Swallow Reports

_____ MRI _____

_____ X-Ray _____

_____ Wheelchair Seating/Evaluation

_____ Other: _____

FOR YOUR INFORMATION:

1. You may inspect or copy the protected health information described by this authorization. A request form is available.
2. This authorization may be revoked in writing at any time, but the revocation will not apply to any PHI previously released in reliance upon this authorization.
3. Information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
4. Neuro Institute will not refuse treatment or services based on your refusal to sign this authorization.
5. The practice may charge or receive a fee for the copying and delivery of the records. You will be notified, in advance, if you will be charged a fee.
6. You have a right to a copy of this authorization, once signed.

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Continued...

Signature of Patient/Representative

Date

Printed Name of patient/representative

Relationship to Patient

REQUEST TO REVOKE AUTHORIZATION

Date: _____ Time: _____ am/pm

I request that this authorization be revoked. I understand that medical or other information already disclosed because of this authorization is not subject to the revocation request.

Signature of patient/representative

Printed name if representative

Date

OFFICE USE ONLY:

DATE RECEIVED: ___/___/_____ TIME: _____ am/pm

Printed Name of Staff Member who reviewed form