NEUROLOGY CENTER, P.A.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand the there will be no charges for these record copies to the physician to whom I am asking the records to be forwarded.

Patient Name: _____ DOB _____

Persons/organizations providing information:	**MAIL records to Persons/organizations requesting information:**
_____	_____
_____	_____
_____	_____
_____	_____

Specific description of information (including date(s), if relevant):

_____

_____

Description of <u>each</u> purpose of authorized use or disclosure:

_____

_____

(Note: "At request of [patient's name]" is sufficient when patient initiates authorization and elects not to provide a more detailed statement of purpose.)

Expiration Date

This authorization will expire on ____/____/____ (DD/MM/YR) or on the occurrence of the following event: _____

Revocation **(***Do NOT mail requested information to this address***)**

This authorization may be revoked at any time by notifying NCPA in writing at Neurology Center, P.A., attn: Steve Long, 8555 16th Street, Suite 310, Silver Spring, MD 20910. If I revoke this authorization, I understand that it will not have any effect on actions the Neurology Center, P.A. took before it received the revocation.

Signature of Patient or Patient's Representative_____Date_____

Printed Name of Patient Representative_____

Relationship to the patient _____

Witness:_____Date:_____

***MAY REFUSE TO SIGN THIS AUTHORIZATION ***