AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____ Mobile Phone: _____
How do you prefer we communicate with you ☐ Home Phone (☐ Voicemail Ok) ☐ Mobile Phone (☐ Voicemail Ok) ☐ Email (secure)

I request that my protected health information (PHI) from Clinical Neurology Specialists be disclosed to:
☐ Self (use above information) ☐ Other (specific below)
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip:_____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record: Covering the period date(s) FROM: _____ TO: _____
☐ Neurological Consultation Notes ☐ Follow Up Notes ☐ Laboratory Reports (e.g. Quest, LabCorp) ☐ Radiology Reports
☐ Test Result(s) of: _____
☐ Itemized Billing Records for **Date From**: _____ through **Date To**: _____
☐ Other:_____

I authorize Clinical Neurology Specialists (CNS) **to communicate my health care, which includes discussing my health condition/care coordination/appointment information to** (e.g. spouse, daughter, brother and list their full name)**:**

_____

Please list any family members you **DO NOT** wish CNS to discuss your treatment, care, or appointment scheduling with:

_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):
Note: CNS does not create/manage these; however, they may have been included in your referring provider or hospital records.

Alcohol, Drug, or Substance Abuse Records	☐ Yes ☐ No	Dates:	_____
HIV Testing and Results	☐ Yes ☐ No	Dates:	_____
Mental Health	☐ Yes ☐ No	Dates:	_____
Psychotherapy Records	☐ Yes ☐ No	Dates:	_____

Purpose of request: ☐ Legal ☐ Insurance ☐ Personal Continuation of Care ☐ Other (please specify other on line below):

_____

Disclosure Format (By default CNS faxes to other healthcare providers and facilities):
☐ US Postal Mail – paper ☐ Fax (to healthcare provider/facility only) ☐ Patient Portal (patient only) ☐ E-mail (secure format)
☐ Other (please specify):_____

I authorize the following healthcare provider/clinic/hospital/healthcare facility to release medical records to CNS:

_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the front desk or mailed to CNS Medical Records 1691 W. Horizon Ridge Pkwy, Henderson, NV 89012. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire in one (1) year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)