Authorization for the Use or Disclosure of Protected Health Information

WK Neurology Clinic
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As required by the Health Insurance Portability and Accountability Act of 1996 WK Neurology Clinic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

*_____(print name) hereby authorize the use and disclosure of the following health information that pertains to me for the following purpose(s).

I authorize the following physicians to receive these disclosures of my health information:
(LIST PHYSICIANS YOU AUTHORIZE US TO RELEASE YOUR RECORDS TO)

*

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to WK Neurology Clinic. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire in one year.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, ect. will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

* Signature _____ Date:_____