Dekalb Neurology Group, LLC
Authorization for Use/Release of Protected Health Information

Patient Name: _____

By signing this form, I authorize _____ to use, release or disclose the protected health information described below to:

Name of Person or Organization to Whom Information should be sent:

_____

Address and/or Fax number of Person/Organization to Whom Information should be sent:

_____

I authorize the following information to be sent to Person/Organization named above:

___ Copies of all medical records for the period ___ / ___ / _____ to ___ / ___ / _____

OR

___ Copies of information described below for period ___ / ___ / _____ to ___ / ___ / _____

___ History & Physical Information ___ Lab, X-ray Reports
___ Other (Please Specify) _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS): sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care, treatment for alcohol and/or drug abuse; or similar conditions.

The following information should ***not*** be released, even if occurring during dates above:

_____

I understand there may be information in these records that I would not want released.

I have been provided a copy of Dekalb Neurology Group, LLC's Notice of Privacy Practices and any changes that may be associated with this authorization. I have discussed any concerns I may have about the use, release and disclosure of my health information with Dekalb Neurology Group, LLC's Privacy Office or other appropriated personnel.

I understand that Dekalb Neurology Group, LLC assumes no responsibility for the use of or misuse by others of my health information disclosed under this authorization. I release Dekalb Neurology Group, LLC from all legal liability that may arise from this authorization.

Patient Signature/Patient Representative: _____ Date: _____

SS#: _____ DOB: _____

If the signature above is not that of the patient, I am acting for the patient because

_____

My relationship to the patient is: _____ Signed: _____

The patient or their representative may revoke this authorization by notifying in writing Dekalb Neurology Associates, LLC's designated Privacy Office. Federal Law states that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal law also requires a statement that there is potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.

Request processed by: _____ Date: _____

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