NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PERSONAL HEALTH INFORMATION (PHI)

PATIENT NAME (PLEASE PRINT): ______________________________

ADDRESS: ______________________________

DOB: __________ SS#: ______________ PHONE #: ____________

RELEASE INFORMATION FROM:

______________________ PHONE: ______________

(Doctor's Name) FAX: ______________

Information to release:

[ ] PROGRESS NOTES ONLY
[ ] TEST RESULTS/LABS ONLY
[ ] OTHER ______________________

PURPOSE FOR RELEASING INFORMATION: ______________________

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RELEASE INFORMATION TO:

NAME: ______________________________
ADDRESS: ______________________________
TELEPHONE: ______________________________
FAX: ______________________________

This Authorization will expire in 1 year from the date signed. After this date, Neurology and Neuroscience Associates, Inc. can no longer use or disclose the patient's PHI without first obtaining a new authorization form.

I Fully Understand and accept the terms of this Authorization.

______________________________ ______________

Patient's Signature or Legal Guardian Date

(IF LEGAL GUARDIAN, PLEASE PROVIDE DOCUMENTATION)

When complete please fax to 330-572-1018 or mail to the address below.

Authorization Verified by: ______________________________

701 White Pond Dr. Suite 300; Akron, Ohio 44320
Phone: (330) 572-1011 Fax: (330) 572-1018