Authorization to Disclose Health Information

I hereby authorize Doylestown Health Neurology to release ALL my Protected Health Information to:

Only Myself ____________

My Spouse/Significant Other (Name) ____

My Children (Name) ____

____

Other (Name) _____________________________________ Relationship _________________________________

_______ I give my permission to LEAVE MESSAGES ON VOICE MAIL regarding test results, answer questions, etc.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (HIPPA) govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that the additional information relating to the exceptions, to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature and should be sent to **Doylestown Health Neurology**.

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above, and in that case, will no longer be protected by HIPAA.

This Authorization expires upon (cessation of treatment; conclusion of course treatment; release from the hospital)

I hereby acknowledge this Authorization

____

Signature of Individual or Personal Representative   Date

____

Description of Personal Representative's Authority

Acknowledgement Statement:

I, ______________________________ (patient name or legal guardian) acknowledge that the Doylestown Health Notice of Privacy Practices has been provided or made available to me on ___________________________ (date).