Authorization to Obtain and / Or Disclose of Protected Health Information

I hereby authorize Neuro Behavioral Center to obtain and/or disclose my protected health information to / from:

Name/Organization of Recipient: * Please enter your primary care provider (or another provider with whom we may coordinate care) Name here

Provider Type: * ☐ PCP ☐ Psychiatrist/Psychiatric nurse practitioner ☐ Therapist ☐ other

Address: Please enter your primary care provider address (or another provider with whom we may coordinate care) here

Phone Number: Fax:

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

I understand that:

1). THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE

2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

3) I may revoke this authorization at any time by notifying Neuro Behavioral Center in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.

4) Neuro Behavioral Center agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed

☐ Lab Tests ☐ Imaging ☐ Progress Notes ☐ Medication ☐ Billing Records ☐ Presence/Participation in Treatment ☐ Entire Medical records ☐ All

☐ Other:

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing ☐ Lab Results

Expiration:

This authorization will expire after 2 years from the date of signing or (insert date)

Patient Name:

Patient D.O.B:

Electronic Signature of Patient or Legal Representative

Signature of Witness:

Date: Date:

Name of Patient's Representative (if applicable):

Relationship to Patient (if applicable) Legal Documentation required

☐ Parent or guardian of unemancipated minor ☐ Court appointed guardian ☐ Executor or administrator of decedent's estate ☐ Power of Attorney