

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Legal Name _____ Date of Birth _____

Patient Address _____

City _____ State _____ Zip Code _____

I, _____, do hereby provide Collier Neurologic Specialists, LLC,
 Patient Full Legal Name

_____ to **use** the following protected health information, and/or

_____ to **disclose** the following protected health information:

The protected health information (PHI) is to be used and/or disclosed to the following person or organization:

The PHI is to be used and/or disclosed for the following reason(s):

I understand that, subject to certain limited restrictions, I may inspect or copy the PHI used or disclosed under this authorization. I understand that if the above named person or organization who receives my PHI is not covered by federal or state health care privacy rules, the PHI disclosed may be re-disclosed to another person or organization and that it will no longer be protected by federal and state health care privacy rules.

I understand that I may refuse to sign this authorization and if I refuse, my refusal will not affect my ability to obtain health care treatment from the Practice or my ability to secure payment for this treatment, or my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that I have the right to revoke this authorization at any time by making a written statement that I am revoking this authorization and sending it to the Practice Privacy Officer's attention at the above address. I also understand that if I revoke this authorization it will only affect future uses and disclosures and will not affect any use or disclosure that has already been made by the Practice. This authorization will expire only upon the Patient-Physician relationship termination unless, revoked per the terms above.

Signature of patient or legal representative

 Printed name of patient or legal representative

Date

 Relationship to patient (if applicable)