HIPAA Acknowledgement and Disclosure Form

**Comprehensive Neurology Services, PA**

196 Thomas Johnson DR Suite 120

Frederick, MD 21701

Phone: (240) 566-3130 Fax: (240) 566-3131

**Patient Authorization for Use and Disclosure of Protected Health Information**

By signing, I authorize Comprehensive Neurology Services, PA to use and/or disclose certain protected health information (PHI) about me to other health care providers for treatment purposes, in special situations for law enforcement or judicial purposes as described by the Health Insurance Portability Accountability Act of 1996, and to the following individuals or entities:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization permits Comprehensive Neurology Services, PA to use and/or disclose the following individually identifiable health information about me, including, but not limited to, date(s) of services, type(s) of service, physicians’ notes, procedural results, etc.

This information will be used or disclosed if medically or lawfully necessary at the request of the patient. The practice, under normal circumstances, will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. Comprehensive Neurology Services, PA also provides a full-length description of the Health Insurance Portability and Accountability Act of 1996.

This form and the Notice of Privacy Practices are provided so that I can make an informed decision whether to allow release of the information. I do not have to sign this authorization in order to receive treatment from Comprehensive Neurology Services, PA. I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to retraction by the patient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization expires in one (1) year.

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Patient (or Legally Authorized Representative) Signature (SEAL) Date

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Description of Legally Authorized Representative’s Authority (POA, Guardian) (SEAL)

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Signature of Witness Date