Wayne Neurology, PLC

34815 W Michigan Ave. Wayne, MI 48184 Tel: 734-721-4739 Fax: 734-725-3184

Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Entity Requested to Release Information: _____

Phone/Fax Number: _____

Who will be authorized to receive information - I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below:

Individual/Entity Name: **WAYNE NEUROLOGY, PLC**

Address: 34815 W Michigan Ave. Ste. C Wayne, MI 48184

Phone*: (734) 721-4739 Fax: (734) 725-3184

Email *: wayneneurology@gmail.com

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Check **only** those items of the record to be disclosed:

- ☐ office notes for last three visit only
- ☐ Neuro consult records.
- ☐ lab results, pathology reports
- ☐ record of HIV and communicable disease testing
- ☐ x-rays, MRI / CT Scans
- ☐ ER records/ Discharge Summary
- ☐ Other: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Treatment/ Continuing Medical Care
Other (please specify): _____

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

_____ _____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.