NeuroHealth Center

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www.NeuroHealthCenter.com

Authorization for Release of Medical Information

I,_____, ___/___/___, _____
Name DOB SSN

Authorize NeuroHealth Center, and/or their administrative and clinical staff to disclose my protected health information:

To: _____
_____
_____

The purpose or need for such disclosure is: Continuity of Care other _____

I give permission to release copies of the record described above, I understand that the specific type of information to be disclosed may include: drug, alcohol, or mental health. I understand that I may revoke or cancel this authorization at anytime: with the exception that action has already been taken. This authorization will remain in effect for 180 days or the time period specified below, in order to carry out the purpose for which permission was given. I understand that the facility releasing these records is free from all legal liabilities that may arise from the act. I understand that I have the right to limit the information that is to be released and who can see the information

I understand that I have the right to revoke this authorization, in writing, at anytime by sending such written notification to the practice's Privacy Contact, I understand that a revocation is not effective to the extent that my provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in health plan or eligibility for benefits I (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to the third party.

This Authorization will expire on:
(Expires after 90 days unless otherwise specified)

X_____ _____
Signature of Individual Receiving Services Date

X_____ _____
Signature of Patient/Legal Representative Date

X_____ _____
Witness Date