COLLIER NEUROLOGIC SPECIALISTS, LLC
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

_____	_____	_____
PATIENT NAME	**Date of Birth**	**Verification of Identity** (drivers license, photo ID, passport, social security, personally known.)

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____to release to: _____

_____

(Persons/Organizations authorized to *receive* the information) (Address, street, city, state, zip code)

In the following format: *circle one*

Paper Copy Secure Message (require Portal enrollment) www.myhealthrecord.com

Patient requests records to be faxed to another facility or physician's office. Patient is aware of confidentiality risks involved and releases _____, M.D., from responsibility for this fax.
Fax number _____ **Patient's Initials** _____

The following information is to be released:

- ☐ Office Visits/Consults
- ☐ Entire Record
- ☐ Other _____
- ☐ Radiology Reports
- ☐ Lab Tests

PURPOSE: The purpose of the release of this information is:

- ☐ Insurance or other third party reimbursement
- ☐ At the request of the patient
- ☐ Other _____
- ☐ Pending legal action
- ☐ Continuity of medical care

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (*Circle any/all that are approved*.)

Mental Health Notes **(Requires separate authorization)**	Alcohol/Drug Treatment Info	HIV / AIDS	

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. By circling the above I authorize use and disclosure of such super confidential information.

RESTRICTIONS:
According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law. I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Collier Neurologic Specialists and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Collier Neurologic Specialists will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Collier Neurologic physicians and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

If the purpose of this Authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed.

MY RIGHTS
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2] I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Collier Neurologic Specialists, LLC-Privacy Official
3200 Bailey Lane Ste # 200
Naples, FL 34105
PH: 239-262-8971 FAX: 239-262-5903

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.[3] Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

SIGNATURE

Patient Signature: _____ Date _____

If signed by someone other than the patient, state your legal relationship to the patient:

Printed Name_____ Relationship _____