SHORELINE NEUROLOGY – 180 WESTBROOK RD. BLDG. 5, ESSEX, CT 06426
HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Name

   Address

   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

By signing below, I hereby authorize and request you to release my complete medical records including x-rays, laboratory work, office notes and any special studies. This includes information relating to diagnosis and treatment of any psychiatric illness, drug or alcohol abuse, and/or any confidential HIV related information.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Patient	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
_____	_____	_____
Signature of Guardian or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only		
_____	_____	_____
Received	**Processed By**	**Office Use**