INJURY TELEHEALTH, LLC

WWW.INJURYTELEHEALTH.COM

HIPAA Privacy Authorization Form

I authorize **Center for Neurological Treatment & Research** to use and disclose the protected health information described below to _____ (individual seeking the information).

A. This authorization for release of information covers the period of healthcare from _____ to_____

****OR****

B. All past, present, and future periods.

_____ **** AND ****_____

A. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

☐ ****OR****

B. I authorize the release of my complete health record with the **EXCEPTION** of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I may refuse to sign this authorization and that it is strictly voluntary. I may revoke this authorization by notifying the above person or entity in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that I may see and obtain a copy of my medical records from **INJURY TELEHEALTH** for any reasonable fee if I request it. I have read the above and authorize the disclosure of my protected health information as stated. A copy of this authorization should be retained by the patient. This authorization automatically expires 12 months from the date signed.

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.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)