GREAT VALLEY NEUROLOGICAL ASSOCIATES LLC

11 Industrial Blvd., Suite 204, Paoli, PA 19301 Tel: 610-644-6251 Fax: 610-644-1440

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name _____ Date of Birth _____

Complete Address _____

Home Phone Number _____ Work Phone Number _____

The following individual or organization is authorized to make the disclosure:

_____ GREAT VALLEY NEUROLOGICAL ASSOCIATES LLC

_____ OTHER, PLEASE SPECIFY _____

This information may be disclosed / sent TO and used by the following individual or organization:

Practice Name/Address: _____

City/State/Zip: _____ Phone:_____ Fax: _____

_____ OTHER, PLEASE SPECIFY _____FAX # _____

Treatment dates to be released: _____

Purpose of Request: _____

The following information is to be disclosed: Please circle YES or NO for each item

YES NO Physician Notes
YES NO Imaging reports (CT scans, MRI/MRA, x-rays)
YES NO Complete Record
YES NO Other: _____
YES NO Lab results
YES NO Neurodiagnostic reports (EMG, EEG, EP)

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency syndrome (AIDS) or infection with the immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

RE-DISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS:

a. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study my enrollment in the research study may be denied.
b. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I do not specify an expiration date, event, or condition, this authorization will expire in six (6) months.

_____

Signature of Patient or legal representative Date

_____

If signed by legal representative, relationship to patient