

Authorization Form For Release of Protected Health Information

By signing this form, I authorize Neurological Surgeons of Dallas to use and disclose the protected health information described below.

Patient Name: _____

DOB: _____

DOCTORS SHOULD NOT BE ON THIS LIST. LAW ALLOWS US TO SHARE INFORMATION WITH YOUR REFERRING PHYSICIAN OR FACILITIES WE SCHEDULE YOU FOR APPOINTMENTS, AS NECESSARY.

PLEASE LIST ONLY PERSONS THAT YOU WOULD LIKE FOR US TO BE ABLE TO SPEAK TO REGARDING YOUR HEALTH, TEST RESULTS OR APPOINTMENTS.

1. _____ Phone# _____
2. _____ Phone# _____
3. _____ Phone# _____
4. _____ Phone# _____
5. _____ Phone# _____

If you wish your billing to be sent to any address other than your information sheet, you must provide an alternative address:

Please indicate if "confidential" be placed on any correspondence: Y N

Please provide the phone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home number _____

*****I AM FULLY AWARE THAT A CELL PHONE OR PORTABLE PHONE IS NOT A SECURE AND PRIVATE LINE.***

May confidential messages (i.e., appointment reminders, MRI results) be left on your telephone answering machine or voice mail? Y N

This authorization shall be in force and effective until the following event and/or date:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Rhonda Dooley, Privacy Officer
C/O Neurological Surgeons of Dallas, PA
7515 Greenville
Suite 1030
Dallas, Texas 75231
214-691-2111

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative

Date

Print name of Patient or Representative

Description of Personal Representative's Authority