**Wesley Neurology Clinic, P. C.**

**Authorization for Use or Disclosure of Health Information**

Please PRINT or TYPE and return completed form to the address at the bottom of this page.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**1.** With regard to the information identified in Section 3 below, I authorize Wesley Neurology Clinic, P. C. to send and/or obtain information to and/or from the healthcare provider or organization listed below:

Physician/Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

**2.** The purpose for which the information is being disclosed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** I authorize the disclosure of the following information from my medical record:

( ) Complete Medical Record ( ) Laboratory Results ( ) Progress Note ( ) Test Results

( ) Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** I understand that I have a right to revoke this authorization at any time by presenting my written revocation to Wesley Neurology Clinic, P. C. I understand that the revocation will not apply to information that has already been used or released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate in one year.

**5.** I understand that I can refuse to sign this authorization. I need not sign this form in order to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may no longer be protected by federal confidentiality rules. I am also releasing this office of any responsibilities related to the faxing of those records. If I have any questions about uses or disclosures of my health information, I can contact Wesley Neurology Clinic, P. C. at: