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 Phone 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** or _____**obtain (please mark one)** 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 If this authorization has not been revoked, it will terminate in one year.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:

East Office:
8000 Centerview Parkway, Suite 305
Cordova, TN 38018
(901) 261-3500

North Office:
3950 New Covington Pike, Suite 270
Memphis, TN 38128
(901) 261-3500

_____ _____ _____

Signature of Patient or Personal Representative | Printed Name of Patient or Personal Representative | Date