Advanced Neurosurgery

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

APPOINTMENT REMINDERS:

The Practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are a brief, nonspecific message left on your answering machine. Occasionally, we may also use appointment cards to remind you about the upcoming appointments. If you don't approve of these methods and would alternative reminder methods (i.e. email) please indicate those methods in the space provided.

HOME PHONE # _____ CELL PHONE # _____

WORK PHONE # _____ FAX # _____

REGULAR MAIL _____ APPOINTMENT CARD ___ EMAIL _____

OTHER

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at advanced neurosurgery? (Check one)

Yes _____ No ____ If No, how else may we contact you regarding this information? _____

Please list any other restrictions regarding messages or reminders about your healthcare:

_____

_____

OTHER USES AND DISCLOSURES:

Disclosures of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

_____ I would like the following restrictions regarding the use and disclosure of my health information: _____

_____

_____

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PERSONS AUTHORIZED TO RECEIVE INFORMATION:

Health information which Advanced Neurosurgery collects or receives about you may be disclosed to the following person(s):

_____

Name of person / Relation / Organization

USE AND DISCLOSURE OF INFORMATION:

_____I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Advanced Neurosurgery.

_____I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify):

_____

EXPIRATION DATE OF AUTHORIZATION:

This authorization is effective through_____/_____/_____ unless revoked or terminated by the patient or patient's personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION:

You may revoke or terminate this authorization by submitting a written revocation to Advanced Neurosurgery. You should contact the Privacy Official or other authorized representative to terminate this authorization.

POTENTIAL FOR REDISCLOSURE:

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient or Legal Guardian Date