HUNTERDON NEUROLOGY

HIPAA AUTHORIZATION & DISCLOSURE OF HEATLH INFORMATION

I, _____D.O.B:_____ authorize Hunterdon Neurology to use or disclose my medical information to the following:

- ❑ All Heathcare Providers that I currently see or referred to
- ❑ The following Family/Friends/Caregivers (Name & Phone Number)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

This authorization is good for 1 year

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Patient Signature:_____ Date: _____

IF THE PATIENT IS UNABLE TO SIGN

Signature of Representative:_____ Date:_____

Print Name:

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: