NEUROLOGICAL CONSULTANTS, P.C.
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Denver, CO 80220
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Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 Neurological Consultants, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

Name: _____ **Date:** _____

SSN: _____ **Date of Birth:** _____ **Phone:** _____

I hereby request and authorize **Neurological Consultants, P.C.** to release my personal health information to the following organization, agency or individual(s):

(Please list **a mailing address** in the box provided. Including your own address if you are requesting your personal records.)

I understand that the records to be released may include information pertaining to the following condition(s): Drug Abuse/Alcohol Abuse, Psychological or Psychiatric Conditions, HIV test results, or an AIDS diagnosis and/or an AIDS related condition.

Treatment Date(s): _____

Purpose of Release: _____

Information Requested (check if to be released):

☐ Complete Chart	☐ Physical Therapy notes	☐ Psychological/Psychiatric Evaluations
☐ Physician's Notes	☐ Treatment notes	☐ Billing
☐ Lab reports	☐ Psychotherapy Notes	☐ Other: _____
☐ Diagnostic Studies	☐ Office notes	

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected by HIPAA.

I understand that I may revoke this authorization at any time by contacting Neurological Consultants, P.C. at the above address, Attention: Privacy Officer. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I certify that this request has been made voluntarily.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand there may be fees associated with this request per Colorado regulations as follows: $18.53 for the first ten or fewer pages, $0.85 per page for pages 11-40, and $0.57 per page for every additional page. If a certification or affidavit of medical records is needed there is a $10.00 fee per request.

I understand that this authorization will automatically expire **365** days from date of signature, or as follows: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness/Legal Guardian Date

If patient is unable to sign, please document reason below: