GILBERT NEUROLOGY
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name ____ Date of Birth__________________

Address ____

Daytime Phone Number___________________________ Cell Phone Number________________________

I hereby authorize ____
(Name of Health Care Provider and/or Institution)

____
(Address)

____
(Phone Number) (Fax Number)

("Disclosing Party") to disclose the following Protected Health Information pertaining to the above referenced patient (check the appropriate items, and specify physician/provider names and dates/date ranges, when known):

- Pertinent Information (i.e., all physician/provider transcribed note[s] and all diagnostic test result[s]) ____
- Discharge Summary ____
- History and Physical Exams ____
- Laboratory results ____
- X-rays and/or imaging reports ____
- Other specialty exams and or tests ____
- Operative and/or procedure reports ____
- Entire medical record ____
- Billing records ____
- Other, please specify documents ____

I understand this authorization covers records relating to communicable disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such information exists.

Such records shall be disclosed to:

Gilbert Neurology
Phone: 480-926-0644 **Fax: 480-926-0645**______
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This information will be disclosed for the following purposes:
☐ Continued Patient Care ☐ Other (specify) ____

I understand that my health care providers will not condition treatment on whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that the Disclosing Party has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Disclosing Party. I understand that the revocation will not apply to information that has already been released in response to the authorization.

I understand that this authorization will expire one year from the date of signing unless otherwise specified:
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I understand, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information.

____ ______________________________
Signature **Date**