GILBERT NEUROLOGY
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Daytime Phone Number _____ Cell Phone Number _____

I hereby authorize Gilbert Neurology
(Name of Health Care Provider and/or Institution)
3507 South Mercy Rd Ste 101 Gilbert Az 85297
(Address)
480-926-0644 (Phone Number) 480-926-0645 (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:

_____
_____
_____
_____

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:

_____

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**