HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act - - 45 CFR Parts 160 and 164)

Patient Name: _____

Date of Birth : _____

I (the above named patient) do hereby authorize and request all entities (except those listed below) to release my health information (PHI) to:

Alliance Neurology Consultants
7111 S. Virginia St Ste., D-2
Reno, NV 89511
Ph: 775--870-1230 / Fax: 833-606-1557

In addition to the authorization for release of my PHI described above, **I AUTHORIZE the FOLLOWING INDIVIDUALS or ENTITIES** to access my Protected Health Information (PH) for treatment, test results, prognosis and for billing & payment purposes:

Name: _____ _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I request the following **RESTRICTIONS** to releasing my PHI:

_____

I understand that I am entitled to a copy of Alliance Neurology Consultants Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the office directly.

I am interested in learning about research I may qualify for my medical conditions. YES NO

(Circle your choice)

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

PATIENT SIGNATURE **DATE**