



AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION page 1 of 2

Revocation
Date Revoked: _____
Initials of privacy official _____

Patient Name: _____ Case Number: _____

Address: _____

I authorize NeuroMatrix® to use or disclose my health information as described below.

1. Type of information: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

<input type="checkbox"/> The entire medical record (all information)	<input type="checkbox"/> Consent
<input type="checkbox"/> Physician Order	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Observation Log	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Business Office File	<input type="checkbox"/> Monitoring Worksheet
<input type="checkbox"/> Waveforms	<input type="checkbox"/> Physician Interpretation/Documentation
<input type="checkbox"/> Other: (Describe as specifically as possible)	

2. Recipient of information: The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

Name: _____ Name: _____

Address: _____ Address: _____



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3. Purpose of use/disclosure - This information described on the previous page will be used for the following purpose(s):

____ Initiated at the request of the resident.

____ My personal records

____ Sharing with other health care providers as needed

____ Other (please describe): _____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
5. **For Marketing disclosures only: (Check if applicable)** _____ I understand that the Facility will receive compensation related to the use or disclosure of the requested information.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. Unless I specify differently, this authorization will expire (insert date or event):

8. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Resident or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)