INSTITUTE OF NEUROLOGY
200 South Orange Avenue, Suite 165
Livingston, NJ 07039

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO Institute of Neurology:

PATIENT NAME:_____ **D.O.B.:**_____

S.S.#:_____

I hereby authorize _____ **to disclose my health information to:**
Institute of Neurology
200 South Orange Avenue, Suite 165
Livingston, NJ 07039

The above named patient is currently being treated at the Institute of Neurology and this information is needed as soon as possible for continuing medical care. Please fax the requested information to the following :

Fax#: 973-322-7505

The information to be disclosed to and used by the above is for the following purpose:_____.

This authorization is limited to the following dates of treatment: FROM _____ **TO** _____

Information to be disclosed:

☐ **EMERGENCY ROOM RECORD**	☐ **CONSULTATIONS**	☐ **DISCHARGE SUMMARY**
☐ **HISTORY & PHYSICAL EXAM**	☐ **PROGRESS NOTES**	☐ **COMPLETE RECORD**
☐ **OPERATIVE REPTS & PATHOLOGY**	☐ **LAB, X-RAYS & TESTS**	☐ **ABSTRACT**
☐ **ADMISSION ASSESSMENT**	☐ **MEDICATIONS**	☐ **OTHER**

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS and HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS AND other INFECTIOUS DISEASE information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to The Institute of Neurology. I understand the revocation will not apply to the extent that The Institute of Neurology has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact 973-322-7580.

PATIENT SIGNATURE: _____ DATE:_____

If legal representative, sign below, state relationship and authority to do so **and** attach the document of authority.

LEGAL REPRESENTATIVE:_____ DATE:_____

RELATIONSHIP:_____

WITNESS:_____ DATE:_____
(Two signatures required for Verbal Consent)

ORIGINAL – RECORD **COPY - PATIENT**