PALM BEACH NEUROLOGICAL CENTER
4520 DONALD ROSS ROAD, SUITE 200
PALM BEACH GARDENS, FL 33418

PRIVACY OFFICIAL: MARY ANN RAHE
561-694-1010x103

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

PT #_____ PATIENT DOB: _____

PERSONS AUTHORIZED TO RECEIVE INFORMATION RELATIONSHIP

_____

_____

_____

_____

INFORMATION TO BE RELEASED:

ALL_____

SPECIFIC: _____

_____

- I understand that if the person receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulation, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying PALM BEACH NEUROLOGICAL CENTER in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by PALM BEACH NEUROLOGICAL CENTER before receiving my revocation.
- I understand I may refuse to sign this authorization.

_____

Signature of Patient or Patient's Personal Representative Date

For Personal Representative of the Patient (if applicable):

Name of Personal Representative:_____

Describe relationship/Authority to Act for the Individual(parent, guardian, etc.)

_____