PACIFIC NEUROSCIENCE
MEDICAL GROUP

Last name:_____
First name:_____
DOB: _____

HIPAA PRIVACY: AUTHORIZATION FOR RELEASE OF INFORMATION

Person/Organization Providing the Information:

Pacific Neuroscience Medical Group staff and employees.

Person/Organization to Receive the Information (e.g., spouse, family members, caregivers, etc.; if you do not want anyone other than yourself to have access to your records, write "none" on the first line):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Description of the Information to be Released:

Any and all personal health information in the possession of or known by the staff or employees of Pacific Neuroscience Medical Group, including but not limited to diagnoses, medications, records, prognoses. This includes psychiatric diagnoses, neuropsychological diagnoses, neurological diagnoses, and other medical diagnoses.

Description of Each Purpose for the Use or Release of the Information:

Medical care, communication with family and non-family persons named above, determination of insurance benefits, billing and collection of fees for medical services.

I understand the following:

- I understand that this authorization is voluntary.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.

This authorization for release of the above information to the above named persons/organizations will expire on: _____ *(insert date or write "never" if you do not want this authorization to expire)*.

_____ _____

Patient/Legal Power of Attorney Signature Date