

# Southwest Neurology, PA

## PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices (posted on the wall)

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Signature(s)

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient Representative (required if minor or adult unable to sign)

\_\_\_\_\_  
Relationship of Patient Representative to Patient Date

\_\_\_\_\_  
Relationship of Patient Representative to Patient Date

## PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

**Information to Be Used or Disclosed**  
The information covered by this authorization includes:

all Information In my files, or  \_\_\_\_\_

**Purposes of Disclosure**

Information listed above will be disclosed for the following purposes:

education, discussion of treatment plan, medical decision making, or  \_\_\_\_\_

**Persons Authorized to Use or Disclose Information**

Information listed above will be used or disclosed by: Southwest Neurology, PA.

**Persons to Whom Information May Be Disclosed**

Information described above may be disclosed to:

Name of person/organization: \_\_\_\_\_, Phone # \_\_\_\_\_, Relationship to patient: \_\_\_\_\_

Name of person/organization: \_\_\_\_\_, Phone # \_\_\_\_\_, Relationship to patient: \_\_\_\_\_

**Expiration Date of Authorization**

This authorization is effective unless and until revoked by the patient or the patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

**Rights of the Individual:** You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

**Effect of Refusing Authorization**

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

\_\_\_\_\_  
Treatment conditioned on authorization

\_\_\_\_\_  
Signature(s)

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Patient Representative to Patient