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 undersand 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