PALM BEACH NEUROLOGY
4631 N. CONGRESS AVE. STE 200
WEST PALM BEACH, FL 33407
(561) 845-0500 FAX (561)845-0587 OR (561)845-1794

AUTHORIZATION TO USE AND OR DISCLOSE HEALTH INFORMATION

I, _____, DOB_____, SSN_____
Authorize (provider name) _____
To use and or disclose my health information as identified below:

_____
Telephone and fax numbers of provider you are requesting this information from:

Phone number _____ Fax _____
Phone number _____ Fax _____

Forward medical records to _____

By initialing spaces below, I specifically authorize the use or disclosure of the following health information and/or records if such information and or records exist.

____ Lab reports
____ Billing Statements
____ Emergency and urgent care records
____ Diagnostic imaging reports
____ Clinician notes
____ Other

The following items must be initialed to be included in the use of disclosure of health information:

____ HIV/AIDS related health information/or records
____ Mental health information or records
____ Drug/Alcohol diagnosis, treatment and or referral information

Federal Regulation requires a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.

I understand that I may revoke the authorization at anytime by giving written notice to PALM BEACH NEUROLOGY. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert applicable date of event of expiration)._____

_____ _____
Signature of individual's legal representative Date

_____ _____
Print the name of legal representative Relationship of legal representative

A copy of this signed form will be provided to the individual and or the individual's legal representative.

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer