Haynes Neurosurgical Group, P.A.

801 Princeton Avenue, Southwest
POB I, Suite 310
Birmingham, AL 35211

Phone: (205) 787-8676 Fax: (205) 785-7944

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, Haynes Neurosurgical Group, PA, may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

Patient Health Information authorization to be disclosed:

_____

For the specific purpose of (describe in detail)

_____

Effective dates for this authorization: ___/____/___ through ____/___/____. This authorization will expire at the end of the above period

I understand that the information disclose above may be re-disclosed to additional parties and no longer protected for reasons beyond out control.

I understand I have the right to:

1. Revoke this authorization by sending a written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____	_____
Signature of Patient or Patient's Authorized Representative	*Date*
_____	_____
Authorized Signature of Facility	*Date*