PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please provide the name(s) of person(s) if any, to whom you will permit discloser of personal health information as necessary for your continued health care. Please note if specific health care information cannot be disclosed (ie; test results, appointment info, etc)

I authorize Clinical Neurology, P.C. to access the medication(s) listed under my insurance or pharmacy carriers.

NAME: ALLOWED DISCLOSURE(s)   please state all/or specify
Spouse:_____ All or Specify:_____
Family/Friend_____ All or Specify:_____
Family/Friend_____ All or Specify:_____

I understand that I may revoke the consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____