2280 Hemby Lane
Greenville, North Carolina 27834

ECN#_________________

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT PURPOSES BY ANOTHER COVERED ENTITY

I, ____(Date of Birth___________________),
am authorizing any current employee or owner of

____
to use or disclose my protected health information as described below.

I have read this authorization and understand what information will be sent, who may send the information, and who will receive the information.

I understand that when the information is sent, as approved by my signature below, federal privacy laws or regulations may no longer protect it. It may be re-disclosed by the receiver. I also understand that I have the right to cancel this authorization, if done so by the steps as listed on the backside of this form (revocation of authorization).

I understand that my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

I give my permission to send my protected health information to**:** ______________________________
EAST CAROLINA NEUROLOGY, 2280 Hemby Lane, Greenville, NC 27834 (252) 413-6825-fax
(Name of Recipient/ Address/Fax Number)

Description of the information to be sent (check all that apply):

- The entire medical record (specify reason:____)
- Demographic information (Name, Address, Phone Number, Date of Birth, etc.)
- Office notes (specify: Most recent visit(s) Current year's visits All visits Other:____________)
- Diagnostic tests/reports (MRI, CT Scan, EMG, EEG, Other_________________________________.)
  Films____
  Neuropsychological Testing ___________________________
- Laboratory data
- Other (specify)____

The purpose of this request is: For continued care; At the request of the patient
Other:____

This authorization will remain in effect for 90 days unless I state otherwise.

I fully understand and accept the terms of this authorization. I understand that signing this authorization is voluntary. I do not need to sign this form to ensure healthcare treatment.

____ _____________________________
PATIENT SIGNATURE DATE

____ _____________________________
AUTHORIZED PERSONAL REPRESENTATIVE DATE
Parent/Legal Guardian
Healthcare POA/POA(copy papers)
Executor or Administrator of Estate (copy papers)
Other :____

____ _____________________________
WITNESS SIGNATURE DATE

____ _____________________________
NOTARY PUBLIC DATE

OFFICE USE ONLY: Patient ID ___________________________________

EAST CAROLINA NEUROLOGY
2280 HEMBY LANE
GREENVILLE, NC 27834

Faxed on _________________ Mailed on ____________ by_____________Filed______________________________

REVOCATION OF AUTHORIZATION
(Cancellation of Authorization)

At all times the patient keeps the right to cancel (revoke) this authorization, except to the extent that the receiving covered entity has already sent the information as described in the authorization. In order for this cancellation (revocation) to be effective, the receiving covered entity must receive your request in writing.

The revocation must include:

The patient's name, address, and date of birth
The effective date of this authorization and the recipients of the protected health information
The patient's desire to cancel this authorization, and
The date of the cancellation and the patient's signature.

Patient may cancel (revoke) this authorization by sending a written request to the covered entity as listed on the front side of this form.: