Northwest Neurological, PLLC

PERSONAL REPRESENTATIVE HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
    Northwest Neurological PLLC   610 S. Sherman Street #201 Spokane WA 99202   (509) 458-7720

2. The following person (or class of persons) may receive disclosure of protected health information about me:

    His/Her/Their Name(s)

    Address

    City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

    _____

    _____

    _____

    UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
    YES, DISCLOSE THIS INFORMATION *_____
    NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying _____Northwest Neurological PLLC_____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information is for _____ .

7. This authorization expires on _____, 20_____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places for individuals with personal representatives. *

Signature of Individual*	**Date of Individual's Signature**	**Date of Birth or**
(The person about whom the information relates)		**Social Security Number**

OR, if applicable –

Signature of Guardian* or	**Date of Guardian's/Personal**	**Description of Authority to Act**
Personal Representative of Patient's Estate	**Representative's Signature**	**for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signatory