AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Central Nebraska Neurology to use and disclose a copy of the specific health and medical information described below regarding:

(Name of Patient)_____

consisting of: **(Describe information to be used/disclosed here)**

Name of Recipient:_____

Or Class of Recipient:_____

for the purpose of: **(Describe purpose of disclosure here)**

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

Send information to: CENTRAL NEBRASKA NEUROLOGY, P.C.
LANDMARK CENTER
2727 WEST 2ND STREET, SUITE 340
HASTING, NE 68901
(402) 463-1250 FAX (402)463-1461

- We cannot condition our provisions of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance of this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____
(Patient)

Or By: _____ Date: _____
(Patient's Representative)

Description of Representative's Authority _____

_____

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