NEWTON-WELLESLEY NEUROLOGY ASSOCIATES, P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Newton-Wellesley Neurology Associates, P.C. to release health information, including copies of my medical records, to the following:

*(List the names of **Family and Friends** we would be authorized to speak with - no need to list Physicians)*

	Name	Relationship to Patient	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

PLEASE READ AND INITIAL

1.) I understand that **the type of treatment I receive will not be based upon whether or not I provide authorization**, except in limited circumstances. For example:
   a. if the treatment is research related, in which case I will sign a different release.
   b. if the treatment is necessary for the purpose of disclosure to a third party such as for physical examination for school or employment purposes.

INITIAL:_____

2.) I understand that **I have a right to revoke this authorization at any time**.
I understand that my revocation must be in writing.
I understand that such revocation does not affect any action taken by NWNA before NWNA received my written notice.

INITIAL:_____

3.) I understand that **the information used or disclosed may be re-disclosed by the recipient named above**.
I understand that my information may no longer be protected by federal privacy regulations or other applicable state or federal laws if such information is re-disclosed by the recipient named above.

INITIAL:_____

4.) I understand that **I may see a copy of the information described on this form** if I ask for it.
I understand that I may obtain a copy of this form after I sign it.

INITIAL:_____

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature of Patient or Guardian Today's Date

_____
Name of Guardian (if applicable)