SILVER STATE NEUROLOGY

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____
Name of Healthcare Provider/ Physician/ Facility

RE: Patient Name: _____ Date of Birth: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, progress notes, clinic records, treatment plans, test results, histories, photographs, telephone messages, and records received by other medical providers.

All radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films and reports.

You are authorized to release the above records in the above-entitled matter to supply copies of such records to:

Silver State Neurology
2575 Montessouri St. Ste 110
Las Vegas, NV 89117

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Name of Patient Date

_____ _____
Signature of Patient Witness