DOUGLAS NEUROLOGY ASSOCIATES, P.C

PATIENT POLICY AGREEMENTS

HIPAA Authorization Form

Douglas Neurology Associates, PC. has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy Policy & Accountability Act) DOES ALLOW us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

PLEASE SEE THE RECEPTIONIST WITH ANY QUESTIONS PRIOR TO SIGNING THIS AUTHORIZATION FORM.

I, _____am authorizing the person/people listed below to discuss medical information about myself. I understand that Douglas Neurology Associates, PC. is not responsible for the information provided as long as it is given to a person I have listed below.

This is not an authorization to release my medical records on file at Douglas Neurology Associates.

Date of Birth must be provided so that our office can verify that we are speaking with the correct person

1. Name: _____ Date of Birth: _____
2. Name: _____ Date of Birth: _____
3. Name:_____ Date of Birth: _____
4. Name: _____ Date of Birth: _____

Patients Signature:_____Date:_____

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I, _____do not authorize Douglas Neurology Associates, PC. to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices

Patient's Signature:_____Date:_____