NORTH VALLEY NEUROLOGY AND SLEEP
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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Phone: (602)482-2116
Fax: (602)482-9563

I hereby authorize:

____
Name of Disclosing Party

____
Address

____
City State ZIP

Phone #__________ Fax #__________

To disclose to:

____
Name of Recipient

____
Address

____
City State ZIP

Phone #__________ Fax #__________

records and information pertaining to:

______________________ ____________ ____________
Name of Patient SS# Date of Birth

______________________ ____________
Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here __________(date).

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

SPECIFY RECORDS: Check the box and sign to specify which type of information is to be disclosed.

- ☐ MEDICAL INFORMATION ______________ Signature ______ Date
- ☐ PSYCHIATRIC INFORMATION ______________ Signature ______ Date
- ☐ DRUG/ALCOHOL INFORMATION ______________ Signature ______ Date
- ☐ RESULTS OF AN HIV TEST ______________ Signature ______ Date
- ☐ GENETIC RECORDS ______________ Signature ______ Date
- ☐ OTHER HEALTH INFORMATION (Specify Below) ______________ Signature ______ Date

Specify the records to be disclosed______________________________

The recipient may use the health information authorized on this form for the following purposes:______________________________

A copy of this authorization is as valid as the original.
Patient has a right to a copy of this authorization.

__________ ______________ ______________
Date Signature If Signed by Other than Patient, Indicate Relationship