Neurology Associates of North Florida

1550 Roberts Drive Jacksonville Beach, FL 32250 Phone (904) 249-4456 Fax (904) 249-7703

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient:_____ **Last 4 SSN:** _____ **DOB:** _____

Information to Be Used or Disclosed
The information covered by this authorization includes:

_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

_____
Name of Person/Organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of Person/Organization

Expiration Date of Authorization: This authorization is effective through _____ unless Revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to **NEUROLOGY ASSOCIATES OF NORTH FLORIDA, INC.**

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulation.

_____ _____
Name of Patient (Print) Signature of Patient Representative

_____ _____
Signature of Patient Patient Representative Name and Relationship

_____ _____
Date Witness