Authorization For The Use And/Or Disclosure Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (please check all that apply):

   ☐ DISCHARGE SUMMARIES
   ☐ PROGRESS NOTES
   ☐ MEDICATIONS
   ☐ HISTORY AND PHYSICAL EXAMS
   ☐ LAB REPORTS

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

(TEL):	(FAX):

3. I authorize the following persons (or class of persons) to receive my protected health information:

   AZIZ SHAIBANI, MD, FACP, FAAN
   NERVE AND MUSCLE CENTER OF TEXAS
   (TEL) 713-795-0033 (FAX) 713-796-9302

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires _____

7. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Houston Neurocare, P.A., nor will it affect my eligibility benefits.

9. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

DOB:

I certify I have received a copy of the authorization.

SIGNATURE _____ DATE _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____

OR

NAME OF PERSONAL REPRESENTATIVE _____