Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: ____ **DOB:** ________________________

The information covered by this authorization includes: ____

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Persons authorized to use or disclose information is Neurological Specialties, 2816 W. Virginia Ave., Tampa, FL 33607, fax # 813-870-0350.

Person(s) or organization(s) to whom information may be disclosed: ________________________________

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Please provide the address and/or fax number where records should be sent: ________________________

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This authorization is effective through ____________________________, unless revoked or terminated by the patient or the patient's personal representative. Revocation or termination must be submitted in writing to Neurological Specialties.

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 regulations after disclosed by Neurological Specialties.

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Signature of Patient or Patient's Representative **Date**