Account # _____

Asheville Neurology Specialists, P.A.

31 Dogwood Rd, Asheville, NC 28806
Phone: (828) 210-9300 Fax: (828) 210-9319

Authorization to Share Protected Health Information

Patient Information:	
Name:	
DOB:	

This will serve as authorization for Asheville Neurology Specialists to share and/or receive my protected health information.

SEND / RECEIVE (circle one) information TO / FROM (circle one):	
Name of Facility or Individual:	
Address:	
Phone:	
Fax:	
Email:	

Description of PHI to be shared:	

Rights of the Patient:

I understand that I have the right to revoke this auhtorization at any time by sending a written notification to Asheville Neurology Specialists at 31 Dogwood Rd., Asheville, NC 28806. I understand that revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal or state law.

This authorization shall be in force and effect until I revoke it; at which time this authorization to use or disclose this protected health information expires.

_____ **Date:**_____

Signature of Patient or Personal Representative

_____

Print or Type Name of Personal Representative

_____

Description of Person Representative's Authority (attach necessary documention)

For Office Use
Records FAXED MAILED PICKED UP EMAILED (circle one) Date: Initials: