NeuroCare
CENTER FOR SLEEP

Authorization for Use and Disclosure of Protected Health Information

Patient Full Name: _____ Patient Date of Birth: _____

I hereby authorize **Neurocare, Inc.** to use and/or disclose my Protected Health Information to the following person/place/entity:

☐ Mail to ☐ Hold for pick up by ☐ Fax ☐ Email*

Name: _____ Fax: _____ Email: _____

Address: _____

**Sending medical records through email is not a secure method and may put your medical records and personal information at risk. By signing below you acknowledge and understand the potential risks associated with sending protected health information through non-secure email and you agree to your records being sent by mail.*

Purpose of Disclosure (please check one):**

☐ Personal Use ☐ Medical Care ☐ School ☐ Insurance ☐ Legal Matter

☐ Other (please specify) _____

*** A $.50 per page fee will apply to requests to send medical records to non-health providers*

Information to be released (please specify the information to be released pursuant to this authorization):

_____

Dates of care included: _____ to _____

I understand and agree that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- If I refuse to sign this authorization, my treatment, payment, enrollment or eligibility for benefits will not be affected.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to such revocation in reliance on this authorization. Further details may be found in the Notice of Privacy Practices.
- Neurocare cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Neurocare may or may not protect this information once it has been released to the Recipient' and the information may be subject to re-disclosed by the recipient.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- My questions about this authorization form have been answered.
- This authorization will automatically expire, unless otherwise revoked, in 6 months unless I specify a date below.

EXPIRATION DATE OR EVENT: This authorization will automatically expire 6 months from the date of signature unless otherwise specified:

_____ or _____

Date of expiration (no later than one year from now) Expiration event

COPY PROVIDED: Neurocare, Inc. shall provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Massachusetts state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by Neurocare, Inc.: information pertaining to my HIV status, records of mental health care and treatment, records of abuse, records of care and treatment for sexually transmitted disease, and records of substance abuse care and treatment.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient