United Neuroscience, Inc.

3330 Stockdale Highway, Suite 200, Bakersfield, CA. 93311, United States.
Phone: 661-324-0500 Fax: 661-324-0600

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Authorization

I authorize **United Neuroscience Institute**, its physicians, employees, and authorized representatives to disclose my protected health information to:

Name of Individual/Organization: _____

Relationship to Patient (if applicable): _____

Phone Number: _____ Email Address (if applicable):
_____

Information to Be Released (Check all that apply)

☐ All Records
☐ Office Visit Notes
☐ Imaging Reports
☐ Laboratory Results
☐ EEG Reports
☐ Operative Reports
☐ Billing Information
☐ Appointment Information

Method of Disclosure (Check all that apply)

☐ In Person
☐ Telephone
☐ Mail
☐ Secure Email
☐ Fax

Expiration

This authorization will expire on:

☐ Never **OR** ☐ Date: _____

Patient Rights

I understand that:

- I may revoke this authorization at any time by submitting a written request to United Neuroscience Institute, except to the extent action has already been taken in reliance on this authorization.
- Information disclosed pursuant to this authorization may no longer be protected by federal or state privacy laws if redisclosed by the recipient.
- I have the right to receive a copy of this signed authorization.

Signature

I have read and understand this authorization and voluntarily authorize the disclosure of my protected health information as described above.

Patient Signature: _____ Date: _____

Office Staff Identity Verified By: _____