Be Mobile Neurology

Authorization for the Release of Protected Health Information

E-mail completed form to drboland@bemobileneurology.com.

Please call 813-981-4403 with any questions.

- Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information with the person you have indicated below.
- This authorization is voluntary.
- Right to revoke : If you decide you do not us to share your health information any longer, sign the revocation at the end of this form and give this form to the front desk. If we have shared your health information for a research study, We may continue to use or share your health information for that purpose only.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- We cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact the our privacy officer to get a copy if you do not have one.

Print Name: _____

Social Security Number:_____ DOB:_____

RECORDS WILL BE SENT VIA E-MAIL ONLY
THE BELOW MUST BE COMPLETE IN ORDER FOR RECORDS TO BE SENT:

I give permission to **Be Mobile Neurology** to share my health information with:

Name: _____

Complete Address: _____

Phone/Fax/AND **e-mail**: _____

So that this person(s) may assist me with my health care issues.

Be Mobile Neurology may share my health information on this authorization form until I revoke the authorization.

I request that the following health information be shared:

- ☐ All of my health care information
- ☐ Information regarding prescription drug coverage
- ☐ Information regarding treatment for drug or alcohol abuse
- ☐ Information regarding behavioral health services or psychiatric care
- ☐ Information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- ☐ Other:_____

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient:_____ Date:_____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative:_____ Date:_____

Relationship to Patient:_____