



**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

HIPAA (Health Insurance Portability Accountability Act) privacy rules give you the right to request a restriction of your protected health information. You are also provided the right to request confidential communications or that communications to be made via alternative means such as sending information to your place of employment instead of your home.

**I WISH TO BE CONTACTED AT THE FOLLOWING NUMBER:**

\_\_\_\_\_  
**(YOU MAY BE LEFT A DETAILED MESSAGE CONCERNING YOUR  
APPOINTMENT OR OTHER DETAILS OF YOUR MEDICAL CARE AT THIS  
NUMBER)**

**Please list any family member/person whom you will permit your  
medical/billing information to be shared with.**

: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_ Telephone: \_\_\_\_\_

This authorization will expire on: \_\_\_\_\_

I do not have to sign this authorization in order to receive treatment from Neurology Group of Bergen County, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

**Signed by:** \_\_\_\_\_  
Signature of Patient or Legal Guardian      Relationship to Patient

\_\_\_\_\_      \_\_\_\_\_  
Patient's Name      Date