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NCV-EMG-EP-EEG NEUROIMAGING INTRAOPERATIVE MONITORING

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Kane Hall Barry Neurology to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Kane Hall Barry Neurology to use or disclose my PHI to:

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

This authorization will expire on: _____ (Expiration Date or Defined Event)
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 Kane Hall Barry Neurology has acted in reliance upon this authorization. My written revocation must be submitted to Kane Hall Barry Neurology' Privacy Officer at 1305 Airport Fwy, Suite 205, Bedford, Texas 76021.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Print Name of Patient or Legal Guardian

Patient SSN & DOB