Fort Wayne Neuropsychology

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Limited Patient Authorization for Disclosure of Protected Health Information (PHI)

Please print all information. Form must be signed and dated each year.

Patient name _____ Date of birth _____

Address _____

1. Purpose of request (who will be authorized to receive and/or provide information)

I authorize Fort Wayne Neuropsychology, LLC to

☐ RELEASE and/or ☐ RECEIVE (please check all that apply per your preference)

protected health information about me to the individual or entity listed below (NOTE: separate releases required for each individual or entity):

Name: _____

Address: _____

Fax: _____

**Secure Communication

- Please note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.
- If you are asking our practice to send the link to set up your patient portal account to an email address ***OTHER THAN YOUR OWN***, we strongly recommend you change your password immediately after setting up your portal account to maintain security of your PHI.

2. Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the individual or entity identified above:

☐ Entire patient record

☐ Indicate specifically the information being requested or to be disclosed:

_____

3. Purpose of disclosure (please indicate the purpose of the disclosure or check patient request):

☐ Patient request ☐ Coordination of care

☐ Other (please specify): _____

4. I understand that this authorization will expire on _____/_____/_____(MM/DD/YR) (1 year) or at the end of the specified event, which is _____ Initials: _____

5. I understand that I have the right to terminate this authorization at any time by submitting a written request of FWN's Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. Initials: _____

- The practice places no condition to sign this authorization on the delivery of healthcare treatment.
- You have the right to receive a copy of signed authorizations upon request.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient or authorized representative signature _____ Date _____

Printed name _____ Relationship to patient (self, parent, etc.) _____