Neurology Specialists
2020 E. Desert Inn Rd.
Las Vegas, NV 89169
Tele: (702) 796-5505 Fax: (702) 732-9830

Srinivas N. Halthore, M.D.
Donald W. Johns, M.D.
Alfreda I. Maller, M.D.

Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name	**Date of Birth**	**Social Security Number**

Address (number, street, city, state, zip code)	**Telephone Number**

The following Individual or Organization is authorized to make the disclosure

- ☐ **Neurology Specialist**
- ☐ **Other (please specify)** _____

This information may be disclosed to and used by the following individual or organization

- ☐ **Neurology Specialist**
- ☐ **Other (please specify)** _____

Treatment Dates	**Purpose of Request**

The following information is to be disclosed (please check one box for each item

YES	**NO**	
☐	☐	..... **COMPLETE RECORDS**
☐	☐	..... **Lab results**
☐	☐	..... **X-ray reports**
☐	☐	..... **MRI / CT scans**
☐	☐	..... **Diagnostic studies**
☐	☐	..... **Physician notes**
☐	☐	..... **Other (please specify)** _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of this health information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (if I do not specify an expiration date, event or condition, this authorization will expire in six months)

Signature of Patient, Parent, Guardian or Legal Representative	**Date**

If Signed By Other Than Patient, Print Name and Relationship To Patient