Northwest Neurology & Electrodiagnostic Center | Ashish Trivedi, M.D.
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Authorization to Disclose Health Care Information

Patient Name:_____ **Date of birth:**_____
Previous Name: _____

My Authorization: You may disclose the following health care information (check all that apply):

- ❒ All health care information from my medical record
- ❒ All billing records
- ❒ Health care information in my medical record relating to the following treatment or condition:
  _____
- ❒ Health care information in my medical record for the date(s): _____
- ❒ Other (e.g., X rays, diagnostic tests, labs, billing information) please specify:
  _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ❒ HIV (AIDS virus)
- ❒ Sexually transmitted diseases
- ❒ Psychiatric disorders / mental health
- ❒ Drug and/or alcohol abuse

You may disclose this health care information to (please list name, address, phone and fax number):

Reason(s) for this authorization (check all that apply):

- ❒ At my request
- ❒ Other (specify) _____

This authorizations ends: *(this document does not permit disclosure of health care information created more than 90 days after the date it is signed.)*

- ❒ In 90 days from the date signed
- ❒ on Date: _____ (no longer than 90 days from date signed)

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by this office based upon this authorization. Once healthcare information is disclosed, the organization that receives may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc)

_____ _____
Witness Signature Witness Printed Name