

NEUROLOGICAL ASSOCIATES, P.C.
 500 WEST BROADWAY, SUITE 310
 MISSOULA, MT 59802-4012
 TELEPHONE (406) 728-6520

NOTICE TO PATIENTS: By signing this form, you are giving permission for Neurological Associates, P.C. and the following to use and share confidential information about you.

PATIENT IDENTIFICATION:			
NAME:		DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER ()	OTHER INFORMATION		
CONSENT: The following individual or organization is authorized to make the disclosure: _____ Neurological Associates _____ Other (specify) _____			
The information may be disclosed to and used by the following individual or organization:			
NAME		TELEPHONE NUMBER ()	FAX NUMBER ()
ADDRESS	CITY	STATE	ZIP CODE
INFORMATION REQUESTED:			
I authorize and consent to the following records and information to be released (initial all that apply):			
_____ Consultation Reports	_____ Radiology Reports	_____ Correspondence	
_____ Follow - up Reports	_____ Laboratory Results	_____ Billing Statement	
_____ Other: (please specify) _____			
Cover the period (s) of health care From (date): _____ to (date) _____			
Please specify the reason for you request:			
_____ Medical Care	_____ Disability	_____ Insurance	
_____ Other _____			
PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include these records. I authorize the disclosure of the following records (initial all that apply):			
_____ Mental Health	_____ HIV/AIDS and STD test results, diagnosis, or treatment	_____ Chemical Dependency (CD services)	
<ul style="list-style-type: none"> ▪ This consent is valid for 6 (six) months. ▪ This release is subject to revocation at any time. The revocation is effective from the time it is communicated with Neurological Associates. If not revoked, the release is terminated in accordance with Montana Code Annotated: Health Care Information, 50-16-527. ▪ I understand that records shared under this consent may no longer be protected under the laws that apply to Neurological Associates, P.C. ▪ A photocopy of this authorization shall have the same force and effect as an executed original. ▪ I do hereby acknowledge that I have read, am familiar with, and fully understand the terms and conditions of this consent. 			
SIGNATURE	DATE	WITNESS SIGNATURE	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)		TELEPHONE NUMBER ()	DATE
If I am not the subject of the records, I am authorized to sign because I am the : (attach proof of authority)			
_____ Parent	_____ Legal Guardian (attach court order)	_____ Personal Representative	_____ Other: _____

NOTICE TO RECIPIENTS OF INFORMATION: If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person the whom it pertains or as otherwise permitted by 42 CFR part 3. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.