NEUROLOGY CENTER OF FAIRFAX, LTD.

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Authorization to Access Protected Health Information

Patient Name _____ Date of Birth _____

This form is used to authorize access and disclosure of Protected Health Information (PHI) to third parties (such as family members, care givers or legal representatives). The form authorizes the specific persons named below to have access to your medical information. This form is not used to order medical records to be sent to others. **Read carefully what you are authorizing.**

1. I hereby authorize the Neurology Center of Fairfax, Ltd. (NCF) to use or to disclose my Protected Health Information (PHI) described here with any limits specified.

   _____

   _____

   I authorize access and disclosure of the described information to the following individuals or organizations.

   _____

   _____

2. The purpose of these authorizations is _____

   _____

3. I understand that upon request, I may receive a copy of this signed authorization.

4. I understand that information used or disclosed under this authorization might be re-disclosed by a recipient. As a result the information is no longer protected to the same extent of the law that it is when under the sole possession of NCF. I do hereby hold NCF harmless for any uses of my Protected Health Information (PHI) made by the persons or organizations whom I have authorized.

5. This authorization will expire on _____. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that NCF has already acted on it. If I revoke this authorization, I agree to send it in writing to NCF at the following address: Privacy Officer, Neurology Center of Fairfax, 3020 Hamaker Court, Suite 400, Fairfax VA 22031.

_____ Signature of Patient

_____ Printed Name of Patient

_____ Signature of Legal Representative

_____ Date

_____ Authority of Legal Representative

_____ NCF Patient Number