NeuroFaith, LLC

Jeffrey E. Hansen, Ph.D

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize Dr. Jeffrey E. Hansen to use, disclose, obtain my health information during the term of this Authorization to/from the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released/obtained to/from the following recipient(s):

Name: _____
Address: _____
_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ❑ Only the following records or types of health information:

_____

Term: I understand that this Authorization will remain in effect for:

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____ _____

Signature of patient/parent /guardian Date