Kalamazoo Nerve Center, PLLC

Authorization for the use and/or disclosure of protected health information.

1. My authorization applies to the information described below. Only this information as described may be used and/or disclosed pursuant to this authorization (please check all that apply):

☐ ENTIRE RECORD ☐ DISCHARGE SUMMARIES ☐ PROGRESS NOTES ☐ MEDICATION/ALLERGY LISTS

☐ TESTING REPORTS ☐ LAB REPORTS ☐ IMAGING REPORTS AND/OR FILMS

☐ OTHER ____________________

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information (PHI):

Name ____________ Tel: ____________ Fax: ____________

Name ____________ Tel: ____________ Fax: ____________

☐ MOHAMMED J. ZAFAR, MD
KALAMAZOO NERVE CENTER, PLLC

3. I authorize the following persons (or class of persons) to receive my protected health information (PHI):

☐ MOHAMMED J. ZAFAR, MD
KALAMAZOO NERVE CENTER, PLLC
2750 OLD CENTRE RD., SUITE 145
PORTAGE, MI 49024
(TEL) 269-323-0955 (FAX) 269-323-1279

☐

4. My protected health information will be used or disclosed upon request for the following purposes:

☐ my personal records

☐ sharing with other health care providers as needed

☐ other (please explain): ____________________

5. I understand that, if my protected health information (PHI) is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

6. I understand that I have a right to inspect and copy my own information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R.§164.524).

7. I understand that I have a right to revoke this authorization at any time. My revocation must be done in writing and be presented to the office in person. I understand that my revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest the claim under my policy.

8. This authorization will expire twelve (12) months from the date on which it was signed unless otherwise stated: ____________

9. I understand authorizing the use or disclosure of the information identified above is voluntary, I need not sign this form to ensure treatment from the Kalamazoo Nerve Center, PLLC.

____________________ Printed name of patient or legal representative
(if signed by legal representative please state relationship to patient)

____________ Date of Birth

____________ Date

____________________ Signature of patient or legal representative

____________ Date

____________ KNC Staff Initals