

**Wesley Neurology Clinic, P.C.**  
**Authorization for Use or Disclosure of Health Information**

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Please PRINT or TYPE and return completed form to the address at the bottom of this page.

Patient Name: \_\_\_\_\_ Patient Acct #: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

With regard the information identified in Section 3 below, I authorize Wesley Neurology Clinic, P.C. to send and/or obtain information to and/or from the healthcare provider or organization listed below:

Physician/Facility Name: \_\_\_\_\_

Physician/Facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2. The purpose for which the information is being disclosed:

\_\_\_\_\_

3. I authorize the disclosure of the following information from my medical record:

Complete Medical Record  Laboratory Results  Progress Notes  Test Results

Other (please specify): \_\_\_\_\_

4. I understand that I have a right to revoke this authorization at any time by presenting my written revocation to Wesley Neurology Clinic, P.C. I understand that the revocation will not apply to information that has already been used or released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this Authorization has not been revoked, it will terminate in one year.

5. I understand that I can refuse to sign this authorization. I need not sign this form in order to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may no longer be protected by federal confidentiality rules. I am also releasing this office of any responsibilities related to the faxing of those records. If I have any questions about uses or disclosures of my health information, I can contact Wesley Neurology Clinic, P.C. at :

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|--|--|--|--|
| <input type="checkbox"/> 1211 Union Avenue<br>Suite 400<br>Memphis, Tn 38104<br>901-725-8920 Ofc<br>901-725-9436 Fax | <input type="checkbox"/> 3950 New Covington Pike<br>Suite 270<br>Memphis, Tn 38128<br>901-387-2120 Ofc<br>901-387-2127 Fax | <input type="checkbox"/> 8000 Centerview Parkway<br>Suite 101<br>Memphis, Tn 38018<br>901-753-4093 Ofc<br>901-757-7844 Fax | <input type="checkbox"/> 7655 Poplar Avenue<br>Suite 155<br>Germantown, Tn 38138<br>901-624-2960 Ofc<br>901-624-2961 Fax |
|--|--|--|--|

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

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