Limited Patient Authorization for Disclosure of Protected Health Information

Please print in ink or type all information. Form must be signed and dated each year.

Patient Name : _____

SSN (last four digits): _____ **Date of Birth (mm-dd-yyyy):** _____

Date of Procedure/Service (mm-dd-yyyy): _____

Hospital at which services were rendered:

_____

Entity Requested to Release Information:

Computational Diagnostics, Inc. and/or
Clinical Neurophysiological Services, LLC
5001 Baum Boulevard, Suite 530
Pittsburgh, PA 15213-1851

Purpose of Request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information (PHI), about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):
Individual/Entity Name: _____
Address: _____
Phone: _____

Description of information to be disclosed – I authorize Computational Diagnostics, Inc. (CDI) and/or Clinical Neurophysiological Services, LLC (CNS) to disclose the following health information about me to the entity, person, or persons identified above:

❒ Physician Case Notes ❒ Summary Report of Procedure

❒ Diagnostic Testing Results ❒ Only send the following:
_____

❒ Financial history report (previous 3 years only) ❒ Entire Patient Record

Purpose of Disclosure (please record the purpose of the disclosure or check patient request)

❒ Patient Request ❒ Other (please specify):_____

- Unless you specify an earlier termination, this authorization will expire at the end of the calendar year of your dated signature below. You must renew or submit a new authorization after the expiration date in order to continue the authorization. Please indicate the date of expiration if earlier than the end of the calendar year: (mm-dd-yyyy): _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Officer at our Pittsburgh office (address above) or at privacy@cdi.com. Termination of this authorization will be effective upon receipt of written notice, except where a disclosure has already been made based on a prior authorization.
- CDI and CNS do NOT require this document to be signed in order for clinical services to be provided.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of CDI and/or CNS.

_____ _____
Patient or Representative Signature Date (mm-dd-yyyy)

You have the right to receive a copy of signed authorizations upon request.