Limited Patient Authorization for Disclosure of Protected Health Information

Please print in ink or type all information. Form must be signed and dated. Request can be made by mail to the address below or by fax at (412) 681-9990.

Patient Name : ______________________________ **Contact Phone No.** ________________________

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:

❒ Summary Report of Procedure ❒ Full patient testing data

❒ Physician Case Notes ❒ All patient information

❒ Billing Records ❒ Only send the following: ____

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

❒ Patient Request ❒ Other (please specify):____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year (mm-dd-yyyy): __________________
- Information disclosed pursuant to this authorization may include psychiatric, drug or alcohol, or HIV information, if that applies.
- 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 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.

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