Name:
Chart:
Date:

NEUROSCIENCE
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HIPAA STATEMENT

NEUROSCIENCE CONSULTANTS, PLC COMPLIES WITH HIPAA REGULATIONS.

THESE FEDERALLY MANDATED REGULATIONS ARE NECESSARY TO PROTECT PATIENTS' PRIVACY AND CONFIDENTIALLY. A COPY OF THE NEUROSCIENCE CONSULTANTS' HIPAA COMPLIANCE POLICY AND PROCEDURES IS AVAILABLE FOR YOUR REVIEW. YOUR SIGNATURE IS NECESSARY TO DOCUMENT THAT YOU HAVE BEEN INFORMED OF OUR COMPLIANCE WITH HIPAA REGULATIONS.

IT IS OUR PRACTICE THAT WE WILL NOT RELEASE MEDICAL RECORDS OR ANY PATIENTS' HEALTH INFORMATION (PHI) TO ANYONE WITHOUT THE PATIENT'S PRIOR WRITTEN AUTHORIZATION.

I GIVE _____ _____
(PLEASE PRINT THE PERSON'S NAME) **RELATIONSHIP**

PERMISSION TO DISCUSS MY MEDICAL RECORDS AND OR TO MAKE OR CANCEL APPOINTMENTS FOR ME WITH NEUROSCIENCE CONSULTANTS, PLC.

I AGREE THAT NEUROSCIENCE CONSULTANTS, PLC MAY REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS OR THIRD PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES.

THIS IS TO ACKNOWLEDGE THAT I READ AND UNDERSTAND THE ABOVE INFORMATION ON NEUROSCIENCE CONSULTANTS, PLC HIPAA REGULATIONS.

PLEASE PRINT: _____
(PATIENT'S NAME)

SIGNATURE OF PATIENT: _____ DATE: _____