

**WESTERN NEUROLOGICAL ASSOCIATES, P.C.**  
**Authorization to Release the Protected Health Information of:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security Number (optional): \_\_\_\_\_

Release Information TO: Facility/Provider: \_\_\_\_\_

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

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

Request Information FROM  
Facility/Provider: \_\_\_\_\_

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

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

Request Information FROM  
Facility/Provider: \_\_\_\_\_

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

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

**This authorization pertains to the following information:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> All Records        | <input type="checkbox"/> Radiology reports                 | <input type="checkbox"/> Radiology Images (disc only) |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultations                     | <input type="checkbox"/> Progress Notes               |
| <input type="checkbox"/> Lab reports        | <input type="checkbox"/> Other Records as specified: _____ |   |

This Authorization will remain in effect: Until: (Specific Date) \_\_\_\_\_ or  
Event \_\_\_\_\_ or for 180 days from signature date unless otherwise noted.

- \*I am not required to sign this authorization and may in fact refuse to sign this authorization. Western Neurological Associates, will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
- \*If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and no longer be protected.
- \*I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
- \*I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Western Neurological Associates, Compliance Officer. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
- \*If I have any questions about this authorization, I may contact The Compliance Officer at (801)262-3441, who will provide me with more information about this authorization, or about Western Neurological Associates, P.C.'s privacy practices.

**I certify that I have read, signed and received a copy of this Authorization.**

Signature of Patient \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE ALLOW 7-10 BUSINESS DAYS TO PROCESS REQUEST-IF URGENT CONTACT MEDICAL RECORDS**

1151 East 3900 South B150 Salt Lake City Utah 84124

Phone: 801-262-3441 Toll Free 1-800-347-7778

Fax Main Office 801-269-9005 Fax Imaging Center 801-685-6177