NEUROLOGY ASSOCIATES OF SANTA BARBARA
PROTECTED HEALTH INFORMATION DISCLOSURE

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

Please list those people to whom we may disclose protected health information:

1)_____
Name

_____ _____
Tel# Relationship

2)_____
Name

_____ _____
Tel# Relationship

3)_____
Name

_____ _____
Tel# Relationship

CHANGING YOUR MIND ABOUT THIS AUTHORIZATION:
I understand that I may revoke this authorization at any time by giving written notice to the Privacy Offcer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

SIGNATURE: _____

DATE: _____