NEUROLOGY CLINIC
VERITYMD
HOPE, HEAL, ADVANCE

VERITYMD INC/NEUROLOGY CLINIC

AUTHORIZATION FOR THE RELEASE & DISCLOSURE OF PROTECTED HEALTH INFORMATION - OUTGOING

By signing this authorization, I authorize **VerityMD Inc/Neurology Clinic** physicians & associates to release and disclose protected health information about me to:

Name of entity to receive information:

Address (number, street, city, state, zip):

Phone: _____ **Fax:** _____

This authorization permits **VerityMD Inc/Neurology Clinic** physicians & associates to use and/or disclose the following individually identifiable health information about me:
(Specify the information to be released, such as date(s) of service, types of services, test results, etc.)

This information is being released for the following purpose(s):
☐Continuing Patient Care
☐Insurance
☐Personal Use
☐Attorney/Legal
☐Other (specify)
_____

I understand that my health record **may include sensitive information**, such as:

- Sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
- Behavioral and/or mental health services.
- Treatment for alcohol or drug use/abuse.

I understand that this information will be provided **within 15 business days** from receipt of the request, in accordance with **California Health & Safety Code § 123110**.

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I acknowledge that **a reasonable fee may be charged** for preparing and furnishing copies of my medical records, as permitted under California law.

Patient Authorization

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Patient's Date of Birth

Date of Signature
