INSIGHT INSTITUTE OF NEUROSURGERY & NEUROSCIENCE (IINN)

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

1 I, _____, authorize Insight Institute of Neurosurgery & Neuroscience, IINN, to use and disclose protected health information contained in the patient record indicated above, including as applicable:

- Communicable disease and infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS" and AIDS related complex and (specify other, if known)_____.
- Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
- Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

2 Name of person(s) or organization to whom disclosure of my protected health information is to be made:

_____

_____

3. This authorization shall expire 120 calendar days from the date of signature or upon request. I understand that I may revoke this authorization at any time by contacting Medical Records at (810) 732-8336.

4. I understand that the right to revoke this authorization is not approved if:
   - IINN has taken action in reliance upon this Authorization; or,
   - If this authorization was given as a condition for obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

5. I understand that my protected health information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient and the privacy of my personal health information will no longer be protected by the law.

6. Specific type of information to be disclosed (including dates and types of treatment):

_____

_____

By signing this Authorization, I acknowledge that I have read and understand the above information.

_____ _____
Signature of Patient or Authorized Representative Date Signed

_____ _____
Social Security Number Date of Birth

_____
Relationship of Authorize Representative to Patient