SELKIRK NEUROLOGY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Selkirk Neurology maintains a record of the healthcare services we provide. You may ask to see and request a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our **Notice of Privacy Practices** describes in further detail how your health information may be used and disclosed, and how you can access your information. If you would like to review this document, please inquire at the front desk.

By my signature below, I acknowledge receipt of the **Notice of Privacy Practices** at Selkirk Neurology.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Patient Name_____ DOB _____

I authorize permission for the staff of Selkirk Neurology to release my information to the following person(s):

Spouse Name: _____

Other: _____

I give permission to leave messages at my home/cell phone/place of employment regarding appointments, test results, and other medical information, etc.

Home: Yes ____No____ Cell Phone: Yes _____ No ____ Place of Employment: Yes ____ No ____

By my signature below, I authorize the staff of Selkirk Neurology to disclose my private medical information as I have indicated above.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship

This form will expire one year from the date you have signed on and be retained in your medical record.