FAU
LOUIS AND ANNE GREEN
MEMORY AND WELLNESS CENTER
Christine E. Lynn College of Nursing
Florida Atlantic University

Authorization for Use or Disclosure of Protected Health Information
Between Healthcare Providers

Patient Name: _____ Date of Birth: _____

The Memory and Wellness Center is authorized to disclose/obtain health information about me to the healthcare providers listed below. You should consider listing your Primary Care Physician (PCP), Neurologist, and any providers who may be able to assist in your care planning.

I hereby authorize FAU to (check all that apply):

use or disclose my protected health information as indicated below TO:

obtain my protected health information FROM:

1. **Name:** _____ Phone: _____ Specialty: _____

   Initial: _____ **Date:** _____

2. **Name:** _____ Phone: _____ Specialty: _____

   Initial: _____ **Date:** _____

3. **Name:** _____ Phone: _____ Specialty: _____

   Initial: _____ **Date:** _____

4. **Name:** _____ Phone: _____ Specialty: _____

   Initial: _____ **Date:** _____

Information to be released, used, and/or disclosed: (check all that apply):

Neuroimaging Reports: _____

Neuropsychological Reports: _____

Latest History and Physical Exam: _____

Latest Progress Note(s): _____

Latest Lab Reports: _____

All Information & Records _____

Other (please specify): _____

I understand that this health information **may** include sensitive information. By initialing below, I am specifically authorizing the release of information relating to:

_____ INITIAL HERE HIV/AIDS and sexually transmitted disease information

_____ INITIAL HERE alcohol and substance abuse information

_____ INITIAL HERE mental health information (**NOT** including psychotherapy notes)

NOTE: If you are requesting the release of Psychotherapy Notes, a separate Authorization is required.

777 Glades Road Bldg. AZ 79, Boca Raton, FL 33431
Phone: (561) 297-0502 Fax: (561) 297-0505
Email: memorylane@health.fau.edu Web: www.fau.edu/memorywellnesscenter

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I have read and understand the following statements of my rights:

- This authorization will remain in effect for one (1) year or until I revoke it in writing. However, the revocation will not have any effect on any actions taken before its receipt and processing.
- I may see and copy the information described on this form, if requested.
- I am not required to sign this form to receive my health care benefits and my refusal to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the Information Receiver for my treatment, the operation of and payment to the Information Receiver.
- I received the Notice of Privacy Practices and had the opportunity to ask questions about it, as well as the use and disclosure of my health information before signing. The Notice is subject to change at any time.
- I understand that information released pursuant to this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that the charge for copying records is $1.00 per page for the first twenty-five (25) pages and $0.25 for each additional page thereafter. Please allow up to five (5) business days for copies to be made. Fees are waived when health information is released directly to a health care provider for treatment purposes.
- A copy of this authorization is as valid as the original and is subject to its terms and conditions.

Execution by Authorizing Individual or their Authorized Representative:

Printed Name of Patient/Legal Representative: _____ Date: _____

Patient/Legal Representative Signature: _____

Verification of identity (For Office Use)**:** ☐ Driver's License/State ID ☐ Personally Known ☐ Other

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