



ABAY NEUROSCIENCE CENTER

3223 N Webb Rd Ste 1

PHONE 316-609-2600 FAX 316-609-2800

**Authorization When Patient Requests Use or Disclosure
of Protected Health Information**

I hereby authorize Abay Neuroscience Center to disclose the following information:

*[Describe the protected health information to be used or disclosed
in a specific, meaningful fashion]*

to:

*[Identify by name and address the person/entity to whom disclosure is being made
or who will be using the information.]*

This authorization will expire on _____ *[list date or
event, no more than 12 months]*. I understand I have a right to revoke the authorization in
writing except to the extent Abay Neuroscience Center has taken action or has relied on
the authorization. This authorization may be revoked by my requesting revocation in
writing and delivering a copy of the same to Abay Neuroscience Center.

The information used or disclosed under the authorization may be subject to redisclosure
by the recipient and no longer protected by federal privacy laws.

Signature of Patient

Date: _____ DOB: _____ SSN: _____

Signature of Personal Representative of Patient

Description of Representative's Authority to Act for Patient

Date: _____



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(Records will be available approximately 10-14 business days once payment for records has been received).