NJ Neurology, Inc.
400 Center Street
Garwood, NJ 07027
908-232-0200 (tel) / 908-232-0211 (fax)

Romana Kulikova, MD **Pediatric Neurology**

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	**DOB**	**Social Security Number**

Address (Street, City, State, Zip Code)	**Telephone Number**

The following individual or organization is authorized to make disclosure to Dr. Kulikova / NJ Neurology Inc:

- ☐ Pediatrician/
- ☐ _____
- ☐ _____

Dr. Kulikova / NJ Neurology Inc. may disclose information to the following individual or organization:

- ☐ _____
- ☐ _____
- ☐

Treatment dates:	**Purpose of Request:**

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will be in effect until revoked.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.

I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Signature of Patient or Legal Representative	**Date:**

If Signed by Legal Representative, Relationship to Patient