Western Neurosurgery, Ltd.
6567 E Carondelet Dr., Suite 305
Tucson, AZ 85710 (520)-881-8400

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION

I hereby authorize Western Neurosurgery, Ltd., an Arizona professional corporation (the "**Practice**"), to disclose to _____(the "**Recipient**"), any and all of my protected health information, of any kind and description (the "**Records**"). Disclosure under this Authorization is for the following purpose: _____ _____.

This Authorization will remain effective until one-year following the date set forth below or, if no date is set forth below, the date the Company receives this executed Authorization, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the attention of the Practice's Privacy Officer at the Practice's office located at 6567 E Carondelet Dr., Suite 305, Tucson, AZ 85710. I understand that my revocation will not be effective to the extent the Practice has taken action in reliance on this Authorization.

I understand that neither the Practice nor the Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that the Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records that may be protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Patient DOB

_____

Printed Name of Patient or Patient's Representative