# NKL NEUROLOGY PLC
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## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
First Middle Last

DOB: _____ SS: _____ - ____ - _____

I hereby authorize:

_____

to release / to obtain a copy of the following information:

_____

TO: NKL NEUROLOGY PLC, Nida K. Laurin, M.D.

FROM:_____

_____

_____

☐ For continuity of care

☐ Other _____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis, genetic testing and diagnostic testing.

I ☐ do ☐ do not authorize the release this type of information

_____ Date: ____ ____ 20____
Patient or Personal Representative Signature

_____
Description of Representative's authority to the Patient

* This authorization will expire in 365 days