AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign Comprehensive Neurology Center, PA my medical reimbursement benefits under my insurance policies listed above. I understand that services not covered by my insurance are my financial responsibility and are due at time of service unless other arrangements have been made.

HIPAA Notice of Privacy Practices:

I understand that Comprehensive Neurology Center, PA has established a Notice of Privacy Practices that provides information about how my protected health information can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options. I acknowledge that I have received a copy of the Notice of Privacy Practice to read and obtain a copy to keep by requesting one from the front office.

Patient's Signature:_____ Date:_____

1600 Coit Road, Suite 406, Plano, TX 75075 **Phone# 469-977-1010** **Fax#469-977-1155**

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