NEUROLOGICAL AND ELECTRODIAGNOSTIC INSTITUTE OF ST. LOUIS, INC

Patient Name: _____ Date of Birth: _____

I understand that NEUROLOGICAL AND ELECTRODIAGNOSTIC INSTITUTE OF ST. LOUIS, INC (the "Practice) has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at any of the following telephone numbers
_____.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):
_____

_____

_____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective January 1, 2010 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Neurological and Electrodiagnostic Institute of St. Louis, Inc
Attn: Privacy Official
14825 North Outer 40
Suite 330
Chesterfield, MO 63017

_____ _____
Patient's Signature Date: