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CURRENT MEDICATIONS AND/OR SUPPLEMENTS *Please try to use the correct spelling. If you are unsure, write "?"*

Medication/Supplement Name	Dose	Schedule	Date Started

PRIVACY & SECURITY

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of and request for protected health information (PHI) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. NOTE: Uses and disclosures for the Privacy Officer may be permitted without prior consent in an emergency.

With Whom May We Share Your PHI? (Full Name)	Relationship to Patient

**If you are working with an attorney and would like us to disclose your results to them, please list their name above.*

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (if different from above):

☐ Phone: _____ ☐ Email: _____

I hereby authorize CereScan to release to my Referring Physician a copy of my medical records. I understand and agree that all images and medical records generated for and on my behalf will become part of CereScan's expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan to use and replicate all medical information contained in the images and reports for proprietary research, training, teaching or other purposes deemed appropriate by CereScan. In order to protect my identity, I understand that all identifying information will be removed from all images and reports prior to its use.

Signature: _____ Name (Printed): _____ Date: _____

