Neurology Associates of Westchester, PLLC.
19 Bradhurst Avenue, Ste. 2850, Hawthorne, NY 10532
Phone: 914.345.1313 Fax: 914.345.5004

Patient Preferred Method of Communication

It is our office policy NOT to leave any medical information or results in a telephone message without your permission. Please complete the form below to indicate who we have permission to speak with and where we are allowed to leave messages with your Protected Health Information.

Patient Name: _____ Patient DOB: _____
(Last name, First name)

I hereby give permission for the Neurology Associates of Westchester to:

a) Give information regarding test results to:

Name: _____ Relationship: _____ Phone #_____
(Area code-phone#)

b) Leave test results on my Answering Machine/ Voicemail : YES _____ NO _____

c) Emergency Contact Number: _____ Name of Contact_____
** this person will only be contacted if you had an urgent test result and we have been unable to reach you after several attempts**

Designation of Personal Representative

I Designate the following person(s) listed below as my personal representative(s). I understand that this gives the personal representative(s) the same power over my protected health information as I have, including the right to inspect my files, copies of records, authorize disclosures and request amendments and restrictions.

Print Name of Representative: _____ Relationship:_____

Print Name of Representative: _____ Relationship: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have read the notice of privacy practices, according to the HIPAA guidelines.

Signature of Patient: _____ Date: _____

You are agreeing and signing for all 3 Notifications

If signed by person other than patient, please print name, relationship, and reason the patient is unable to sign for themselves:

_____