Consent for the Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations.

I hereby consent to *Neurodiagnostics Inc., Doing Business As Lexington Diagnostic Center* or "The Practice" using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):¤

- ☐ Chemical Dependency/Substance Abuse
  - ☐ Drugs
  - ☐ Alcohol
- ☐ Sexually Transmitted Diseases

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____	_____
Printed name of patient or patient's representative	Relationship of Representative to Patient
_____	_____
Signature of Patient or Patient's Representative	Date