Authorization For Neurosurgery Specialists to Release Medical Information

COST FOR COPIES

Pages 1 - 10: no charge
Page 11: $1.00 charge
Pages over 11: $.50 charge per page

Patient Name: _____

Patient DOB: _____

Patient SSN: _____

I hereby authorize Neurosurgery Specialists to release the medical information described below to the following:

Individual or Company to receive medical information: _____

Mailing Address: _____

Phone: _____ FAX:_____ (up to 10 pages)

How would you like the information to be released (check one):

☐ Mailed to address listed above ☐ Faxed to number listed above ☐ Picked up (We will call you when ready)

Information to be released (check one)

☐ All medical information concerning this patient.

☐ Medical information dated from _____ to _____

Purpose of request (check one)

☐ Self, Employment, Other ☐ Attorney ☐ Insurance Company/Medical Claim ☐ Physician ☐ Disability

By signing below you acknowledge the following:

1. I understand that the medical and health information that may be released could contain records about me that indicate the presence of a communicable or venereal disease such as hepatitis, syphilis, gonorrhea, HIV or AIDS

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and that it will not apply to information that has already been released in response to this authorization.

3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

4. I understand authorizing the use or disclosure of the information identified above is voluntary. I need to sign this form to ensure health care or treatment.

_____ _____ Signature
of Patient or Legal Representative Date

_____
Relationship, if not Patient (Please note: A copy of a Power of Attorney may be necessary.)

INSTRUCTIONS:

Please complete and FAX to (918) 491-3540. Please allow 10 to 14 business days for this request to be processed.

You will be billed for the medial records as noted above.

This authorization will expire six months after date of signature.

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