NEUROSURGICAL CONSULTANTS, INC.

Authorization for Release of Information

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: _____ **Date of Birth:** _____

Persons/organizations providing the information:

_____
_____
_____
_____

Person/organizations receiving the information:

_____
_____
_____
_____

Specific description of information (including date(s)): _____
_____
_____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure? _____
   _____
   _____
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? **Yes** ____ **No** _____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:** _____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ **Initials:** _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. **Initials:** _____

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

_____ _____
Signature of Person Picking up Record & Date **or** **Signature of Employee Mailing Record & Date**

_____ _____
Printed Name of Person Picking up Record **or** **Printed Name of Person Mailing Record**