Neurosurgical Associates, L.L.P.
Release of Protected Health Information

Authorization for: ☐ Disclosure ☐ Inspection ☐ Amendment

Patient Name:	**Date of Birth**	**SS #**	**Chart #**
Address			**Phone #**

I hereby authorize _____

Facility Name

To (*Name/Address of person/organization to which disclosure is to be made)*:

_____

_____

_____

Phone # _____ **Fax #** _____

For treatment dates: _____

Specify date – This line MUST BE completed

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (detail below)

_____

Select Portions

☐ Abstract/Pertinent Information
☐ Lab
☐ Emergency Room
☐ Imaging/Radiology
☐ Nursing Notes
☐ H & P
☐ Cardiac Studies
☐ MD Progress Notes
☐ MD Orders
☐ Face Sheets
☐ Operative/Procedure Report

☐ Entire Record EXCLUDING – HIV Testing & Chemical Dependency.

☐ Entire Record INCLUDING – HIV Testing & Chemical Dependency.

☐ Entire Record INCLUDING – HIV Testing Only.

☐ Entire Record INCLUDING – Chemical Dependency only.

☐ Psychotherapy Notes (If this category is check, NO others can be)

☐ Other _____

This authorization expires one (1) year from the date signed below and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Neurosurgical Associates, L.L.P. to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been take in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information

_____ _____ _____

Date ***Signature of Patient/Parent/Guardian*** ***Authority/Relationship to Patient***