Neurosurgical Associates
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NEUROSURGICAL ASSOCIATES HIPAA AUTHORIZATION FORM

Please read this entire form before signing below

1. I, _____, hereby authorize_____
   To disclose health information regarding my care and continuation of care. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may thus be no longer protected by federal privacy regulations

2.
I specifically request the following persons, providers, or entities to release protected health information about me.

Person or Facility Name: _____
Address: _____
Phone #: _____
Fax #: _____

3. The specific information that should be disclosed is:

A. _____any and all information contained within the patient's medical file or chart at your facility, including but not limited to all handwritten information from the patient, nurse's notes, dictated office notes, diagnostic test results, prescription profiles, surgical procedure information, billing information and restrictions or physical therapy notes with the exception of:

____Substance abuse, if any
____ Psychological or psychiatric conditions, if any
____ AIDS/HIV, if any
____ Other (Please specify): _____

OR

B. _____Other specific information or records: _____

4. I understand that:

a. I may refuse to sign this authorization and that it is strictly voluntary.

b. I may revoke this authorization by notifying the above person or entity in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

c. I understand that I may see and obtain a copy of my records from Neurosurgical Associates for a reasonable copy fee if I request it.

d. I have read the above and authorize the disclosure of the protected health information as stated.

e. A copy of this authorization should be retained by the patient.

f. This authorization automatically expires 12 (twelve) months from the date signed.

Patient Name (Print): _____

Date of Birth: ____/_____/_____ SSN: _____-_____-_____

Patient Signature: _____ Date Signed: _____

A COPY OF THIS AUTHORIZATION FORM WILL BE TREATED AS IF IT WERE ORIGINAL