

**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**