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NEUROLOGICAL SURGERY

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HIPAA CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date:_____ DOB:_____

When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., please indicate where we can leave a message or send mail:

CIRCLE YES OR NO

HOME NUMBER – YES/NO _____

CELL NUMBER – YES/NO _____

MAILING ADDRESS – YES/NO _____

I AUTHORIZE THE FOLLOWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I, _____ agree to the above. Date signed: _____
(Patient Signature)

Signing this form verifies all information is correct and/or has been updated. (update at each visit)

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
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