AUTHORIZATION FORM
To Communicate Treatment

Patient Name: _____ Date of Birth: _____ /_____ /_____
First M.I. Last

Address:_____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR §164.508]. It authorizes Neurosurgical Medical Clinic, Inc., to disclose my medical information/treatment/billing-accounting via:

☐ Voice mail / answering machine

☐ Communication with additional parties:

Name:_____

Relation:_____

Name:_____

Relation:_____

OR

☐ Direct communication with myself only

I understand by checking this box it restricts NMC from leaving a detailed voice mail as well as prohibits NMC from speaking with anyone besides myself.

This authorization must have an expiration date: _____ / _____ / _____

Under the Privacy Rules, I have the right to revoke this authorization at any time, and Neurosurgical Medical Clinic Inc., must cease using this authorization. However, Neurosurgical Medical Clinic, Inc., may complete any actions it initiated prior to my revocation and which rely on my records for completion. I understand that by disclosing my medical information/treatment, Neurosurgical Medical Clinic, Inc., cannot guarantee the recipient will not use or disclose this information in violation of the Privacy Rules.

I must revoke this authorization in writing and send the revocation to Neurosurgical Medical Clinic, Inc., 3750 Convoy Street, Suite 301, San Diego, CA 92111.

Patient Name: _____ Date:_____

Signature: _____

Personal Representative: _____ Relationship to Patient: _____

Signature: _____