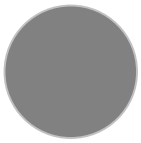

NEUROSURGERY AND SPINE SPECIALISTS

MRN_____

DR_____

CONSENT FOR 3RD PARTY RELEASE

AUTHORIZATION FOR FAMILY, FRIENDS, OR ADVISORS TO RECEIVE INFORMATION ABOUT YOUR MEDICAL CONDITION OR THE STATUS OF YOUR BILL.

I, _____, authorize the following individual(s)
(print name)

to receive written and/or oral communications about my medical condition, care, appointments and the status of my bill. I understand that they will need to be able to provide the last four (4) digits of my social security number for verbal communication. If they should come to pick up a prescription or to discuss my care or the status of my bill, they will need to bring a photo ID.

PLEASE PRINT NAMES OF AUTHORIZED INDIVIDUAL(S)

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____ _____
Patient Signature Date

STAFF INIT & DATE_____

5831 Bee Ridge Road, Suite 100 ● Sarasota, FL 34233 ● 941.308.5700 ● Fax: 941.308.5757