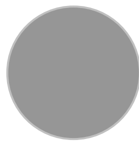

NEUROSURGERY AND SPINE SPECIALISTS

I hereby authorize Neurosurgery and Spine Specialists to use or disclose my PHI as indicated below:

PATIENT INFORMATION

Last Name	First	MI
Date of Birth	Social Security Number	
Address		
City	State	Zip
Daytime Phone Number ( )	Evening Phone Number ( )	

RECORD HOLDER			RECORDS MAY BE RELEASED TO		
Name			Name Dr Mayer Dr Glasser Dr Fine Dr Knego		
Address			Address 5831 Bee Ridge Rd, Ste 100		
City	State	Zip	City Sarasota	State FL	Zip 34233
Phone ( )	Fax ( )		Phone (941) 308-5700	Fax (941) 308-5757	

INFORMATION TO BE RELEASED

Dates Of Service	All From / / To / /			
Types Of Information	All History & Physical Progress Notes	Consultation Reports Laboratory Reports Pathology Reports	Radiology Reports Op/Procedure Reports Discharge Summary	Other
Use Of Information	Continuing Care Legal	Second Opinion School	Personal Insurance	Other

SPECIAL CATEGORIES OF INFORMATION

You Must Specifically Authorize the Disclosure of The Following Types of Information. (Please Check All That Apply)

HIV Testing Results/AIDS Information	Alcohol and/or Drug Abuse Treatment	Psychiatric/Mental Health Records	Sexually Transmissible Diseases

X	
Signature Patient/Legal Guardian/Authorized Person	Date of Signature

I UNDERSTAND THAT:

1.	This authorization may be revoked in writing at any time, according to the instructions in Neurosurgery & Spine Specialists Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization is valid for one year from the date signed below.** A photocopy of this form will be considered as valid as the original.
2 .	Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal regulations.
3 .	I am under no obligation to sign this authorization. My health care and payment for my health care will not be conditioned on signing this authorization.
4.	I may inspect and obtain a copy of any information disclosed. I may be charged a fee of up to $1.00 per page for every page copied.
5.	The practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATIUON.

X	
Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature
Patient/Legal Guardian/Authorized Person (Printed Name)	Relationship If Other Than Patient