AUTHORIZATION FORM

To Communicate Treatment

Patient Name: _____ Date of Birth: _____ / _____ / _____
Address: _____ City: _____ State: _____ ZIP: _____

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
☐ Mail without envelope (i.e. postcard reminders)
☐ 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 detailed voice mail or answering machine messages as well as prohibits NMC from speaking with any family member or friend regarding my treatment or condition.

This authorization expires: _____ / _____ / _____
(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., 2100 Fifth Ave # 200, San Diego, CA 92101.

Patient Name: _____ Date: _____

Signature: _____

Or

Personal Representative: _____ Relationship to patient: _____

Signature: _____