Authorization for Release of Protected Health Information

Neurosurgery Associates, LLC
393 East Town Street, suite 110
Columbus, Ohio 43215
PH: 614-220-5648
Fax: 614-220-5649

I hereby authorize Neurosurgery Associates, LLC to furnish copies of my medical records (PHI) to:

Name of Provider:_____

Address:_____

City;_____ State:_____ Zip:_____

Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results except as specifically listed below:

_____

This authorization is effective now and will remain in effect until _____

I understand that I have the right to receive a copy of this authorization.

Signature:_____Date:_____

Please Print

Name of Patient:_____

Address:_____

City:_____State :_____ Zip:_____

Patient's Date of Birth:_____ Social Security :_____

If not signed by patient, please indicate relationship to patient:

___Parent or guardian of minor patient

___Guardian or conservator of an incompetent patient

___Beneficiary or personal representative of a deceased patient

___Other:_____