AUTHORIZATION AND CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Date of Request: _____ Medical Record Number: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

City, State, and Zip: _____

I authorize _____and affiliates and their employees and agents, my permission to release to NeuroSpinecare, Inc.

This authorization may only be revoked by a written, dated statement of revocation. This authorization cannot be revoked for information already released, information you are not authorized to release, or information used for your treatment, operations, or payment of your claim.

Protected health information and/or photocopies of medical/billing records as stated below:

PERTINENT TREATMENT DATES (on or about): _____

SPECIFIC INFORMATION TO BE RELEASED: _____

This information may include documentation of treatment for physical and/or mental illness, including chemical dependency and HIV (Human Immunodeficiency Virus), ARC (AIDS-Related Complex), or AIDS (Acquired Immunodeficiency Syndrome).

PURPOSE OR NEED FOR DISCLOSURE: _____

This consent remains in effect for sixty (60) days from the date written above, unless I revoke this document in writing prior to the expiration of the 60-day period, and unless action has already been taken by Neurosurgical Services, Inc. and/or affiliates in releasing this information as requested. This authorization pertains *only* to the dates/treatments and entities authorized to receive the information listed above.

By my signature below, I also release NeuroSpinecare, Inc. and all affiliates from any and all liabilities engendered by the release of information as requested above. I acknowledge the above information may be re-disclosed by the recipient and no longer protected.

All personal copies of records are subjected to a fee.

_____ _____

Signature of Patient/Guardian person authorized to consent Date

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