FEIGENBAUM NEUROSURGERY

Specializing in the treatment of spinal meningeal cysts

Frank Feigenbaum, M.D., FAANS, FACS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____, date of birth _____
Print name of patient

Hereby authorize FEIGENBAUM NEUROSURGERY, PA to use and/or disclose my individually identifiable health information as described below:
I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address, City, State, and Zip Code: _____

Phone and Fax Numbers: _____

The following individually identifiable health information may be used and/or disclosed: *Check all that apply:*

☐ Entire chart ☐ Test and x-ray reports ☐ Consultation reports
☐ Inpatient records ☐ Outpatient records ☐ Other: _____

Dates of treatment to be released: _____

Reason or purpose for the use and or disclosure of the information: _____

Expiration: This authorization will expire in 90 days from the date of this authorization unless revoked by the patient prior to this time.
Revocation: I understand that I may revoke with authorization at any time by notifying Feigenbaum Neurosurgery in writing. I understand that if I revoke this authorization, it will not affect any actions that Feigenbaum Neurosurgery took before it received my revocation letter.
I further authorize that a photocopy of this authorization will be as an original. This authorization is binding. I understand that it takes precedence over statements made in the Feigenbaum Neurosurgery Notice of Privacy Practices.

_____ _____
Signature of individual or personal representative *Date*

Printed name of personal representative: _____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian, etc.) _____

Witness Signature _____Date _____