FEIGENBAUM NEUROSURGERY

Specializing in the treatment of spinal meningeal cysts

Frank Feigenbaum, M.D., FAANS, FACS

AUTHORIZATION FOR USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:		**Date of Birth:**	
I authorize the following person(s) or organization to receive the information:			
Name:		**Relationship to Patient:**	
Address:	**City:**	**State:**	**Zip:**
Phone:	**Fax:**		
Method of Delivery:	**Dates of Treatment:**		
□ **Mail** □ **Fax**	□ **All** □ **From: _____- _____**		

I hereby authorize FEIGENBAUM NEUROSURGERY, P.A. to use and/or disclose my individually identifiable health information as described below. 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** □ **Billing Records** □ **Other:**

Reason for Release and Disclosure of Information:

□ **Continuing Care** □ **Referral to a Specialist** □ **Change of Doctor/Provider** □ **Personal** □ **Insurance**
□ **Disability** □ **Legal** □ **Other:**

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, P.A. in writing. I understand that if I revoke this authorization, it will not affect any actions that FEIGENBAUM NEUROSURGERY, P.A. 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.

I understand that released documentation may contain sensitive information regarding substance abuse, alcoholism, drug use, mental health issues, and/or communicable disease diagnosis such as HIV/AIDS, may be disclosed.

_____	_____	_____	_____
Patient Signature	Date	Witness Signature	Date
_____	_____	_____	_____
Representative Name (If Applicable)	Relation	Witness Name	Relation

OFFICE USE ONLY	
File This Release in Patient's Chart	
Date Processed Release:	Total Pages Released:
Release Processed By:	Signature:

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