



FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

Specializing in the treatment of spinal meningeal cysts

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 medical record information:			
Name:		Relationship to Patient:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Method of Delivery: (Default will be Mail unless marked)		Dates of Treatment:	
<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Electronic Media <input type="checkbox"/> Unencrypted Email		<input type="checkbox"/> All <input type="checkbox"/> 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): <input type="checkbox"/> Entire Chart <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> Operative Notes <input type="checkbox"/> Medications <input type="checkbox"/> Lab Reports <input type="checkbox"/> Radiology & Diagnostic Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Billing Records <input type="checkbox"/> Other:			
Reason for Release and Disclosure of Information:			
<input type="checkbox"/> Continuing Care <input type="checkbox"/> Referral to a Specialist <input type="checkbox"/> Change of Doctor/Provider <input type="checkbox"/> Personal <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> 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/Authorized Representative Signature:	Date:
Representative Name (If Applicable):	Relationship to Patient: <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Guardian <input type="checkbox"/> Other
Witness Signature:	Witness Name:

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