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:***	
□ Mail □ Fax □ Electronic Media □ Unencrypted Email		□ 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 □ Consultation Reports □ Progress Notes □ Operative Notes □ Medications
□ Lab Reports □ Radiology & Diagnostic Reports □ Pathology Reports □ 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/Authorized Representative Signature:	Date:
Representative Name (If Applicable):	Relationship to Patient: □ Parent of Minor □ Guardian □ 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:

Main Office: Energy Square 1 • 4925 Greenville Ave • Suite 1307 • Dallas, Texas 75206
AIMIS Spine: Theodorou Potamianou 50 • Kato Polemidia 4155 • Limassol, Cyprus
P (214) 242-1389 • F (214) 366-3713 • frankfeigenbaum.com