NEUROSURGICAL SPECIALISTS, INC.
DIPLOMATES, AMERICAN BOARD OF NEUROLOGICAL SURGERY

DAVID C. WATERS, M.D.
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JEFFREY J. LAURENT, M.D.

ROBERT A. RASHTI, M.D.
RETIRED
(1981-2001)
DANIEL A. WHITE, M.D.
DECEASED
(1940-1983)

Acknowledgement of Receipt of Disability Form(s)

PATIENT'S PLEASE CHECK THAT YOU HAVE SIGNED ALL FORMS AND/OR SIGNED AN AUTHORIZATION TO RELEASE INFORMATION FORM WITH NEUROSURGICAL SPECIALISTS, INC., AS THIS CAN DELAY THE COMPLETION OF YOUR FORM(S).

Patient Name: _____ Date: _____

DOB: _____ Patient ID: _____Physician: _____

Please indicate how you would like your disability form(s) to be disclosed:

_____Fax _____Mail _____Pick-up

Number of forms to be completed: _____

Date received: _____ Received by: _____

Form Fee Payment amount: $_____ Credit Card Check Cash (Circle Method Type)

****PLEASE NOTE THAT WE CHARGE $25.00 PER SEPARATE DISABILITY FORM AND MUST BE PAID BEFORE WE CAN COMPLETE YOUR DISABILITY FORMS. ****

Form(s) completed by: _____ Date: _____
(NSI Staff Name)

____ Faxed to: _____ Fax#: _____
(Name of Company or Person)

____ Mailed to: _____
(Name and Address)

____ Picked up by: _____ Signature: _____
(Print Name and Relationship to Patient)

Date: _____ ID verified by: _____
(NSI Staff Name)

Leigh Professional Center
6261 E. Virginia Beach Blvd. Suite 200
Norfolk, Virginia 23502
PHONE (757) 625-4455 ▪ FAX (757) 625-1829
www.nsinc.org

NEUROSURGICAL SPECIALISTS, INC.

Release of Protected Health Information Form

Patient Name: _____ Patient ID: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Neurosurgical Specialists, Inc.
6261 E. Virginia Beach Blvd. Norfolk, VA 23502

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
__ Office Notes
__ Hospital Reports (Op Notes, Consultation Notes, and Discharge Summaries)
__ X-ray and Imaging Reports
__ Complete Record Set
Other _____
_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:
_____
Address: _____
How to be disclosed: __Mail __Fax __Pick-Up

6. I understand that I have a right to revoke this authorization at any time. I may revoke this authorization at any time by writing to the address above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.**

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Neurosurgical Specialists, Inc. Privacy Contact. 757-625-4455 ext. 3612

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness