



## NEUROSURGICAL SPECIALISTS, INC.

### Release of Protected Health Information Form

Patient Name: \_\_\_\_\_ SSN / Medical Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

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  Records Review  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

**Fee For Records: \$10 copy fee plus \$ .50 per page (page 1-50) and \$ .25 per page (pages 51+)**