NEUROSURGICAL CONSULTANTS, LLP

Patient Protected Health Information
Consent Form

I hereby consent to Neurosurgical Consultants, (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the Practice's healthcare operations. I, also, consent to Practice using or disclosing my protected health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provide or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and healthcare operations, if it is a part of my protected health information: Chemical Dependency/Substance Abuse, Drugs; including Alcohol, Sexually Transmitted Diseases unless you specify otherwise. I further acknowledge the Practice has provided me a copy of its "Notice of Privacy Practices", which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. I authorize other provides to release my protected health information for treatment purposes. I have been given a copy of, and agree to abide by, the Practices financial policies.

Additional Consent To Release Information

I authorize Neurosurgical Consultants to discuss and release medical information regarding my care, scheduled procedures, and to release financial information to the following family members, legal representative, and/or other designee specific:

Name:_____

Relationship_____

Name:_____

Relationship_____

Name:_____

Relationship_____

_____ Date:_____

Signature of Patient or Personal Representative

_____ Date:_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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