

# Authorization For Neurosurgery Specialists to Release Medical Information

Patient Name: \_\_\_\_\_

Patient DOB/SSN: \_\_\_\_\_

I hereby authorize NSI to release the following information to:

Name: \_\_\_\_\_

From: Neurosurgery Specialists

6767 S. Yale, Suite A

Address: \_\_\_\_\_

Tulsa, OK 74136

(918) 492-7587

\_\_\_\_\_

(918) 492-4033 FAX

Patient/guardian to pickup \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ (up to 10 pages)

**Please allow 7 to 14 business days for this request.** This authorization will expire six months after date of signature.

**I understand that the medical and health information that may be released could contain records about me that indicate the presence of a communicable or venereal disease such as hepatitis, syphilis, gonorrhea, HIV or AIDS.**

1. The information to be released is as follows: \_\_\_\_\_ complete record, Or (describe)

\_\_\_\_\_

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and that it will not apply to information that has already been released in response to this authorization.

3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

4. I understand authorizing the use or disclosure of the information indentified above is voluntary. I need to sign this form to ensure health care or treatment.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship if not Patient

Please note: A copy of a Power of Attorney may be necessary.

## **INSTRUCTIONS:**

**Please complete and FAX to (918) 492-4033. You will be billed the following cost for medical records:**

Pages 1 - 10: no charge

Pages 11: \$1.00 charge

Pages over 11: \$.50 charge per page