



# AUTHORIZATION FOR RELEASE OF INFORMATION

## Section A: Must be completed for all authorizations:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Persons/organization providing the information: Orlando Neurosurgery.

Please list all persons or organizations we may release your medical information to: Include family members, insurance companies by name, attorney, Social Security Disability, etcetera:

---

---

Specific description of information: Any and all office notes, hospital reports or laboratory/radiological data generated by this office from my initial contact to present or any part thereof. Specify any other:

---

## Section B: Must be completed only if the health care provider has requested the authorization:

- 1) The health care provider must complete the following.
  - a. What is the purpose of the use of the disclosure: At the request of the individual.
  - b. Will the health care provider requesting the authorization receive financial or in kind compensation in exchange for using or disclosing the health information described above? No.
  
- 2) The patient or the patient's representative must read and initial the following statements:
  - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: \_\_\_\_\_
  - b. I understand that I may see and receive a copy of the information described on this form if I ask for it and that I will be charged for such copy. Initials: \_\_\_\_\_
  - c. I understand that I get a copy of this form after I sign it. Initials: \_\_\_\_\_

## Section C: Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following statements:

- 1) I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_. If no date is entered this authorization will expire in one year. Initials: \_\_\_\_\_
  
- 2) I understand that I may revoke this authorization at any time by notifying the practice in writing, but it won't have any affect on any actions they took before they received the revocation. Initials: \_\_\_\_\_

Signature of Patient or Patient's Representative

Date

## (FORMS MUST BE COMPLETED BEFORE SIGNING)

Printed name of patient's representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_