

Neurosurgical Specialists, Inc.

580 E. Main Street
Suite 200
Norfolk, Virginia 23510
Phone (757) 625-4455
Fax (757) 625-1829

| | | |
|---|--------------|--------------------------|
| Authorization For Release Of Information | | |
| I hereby authorize _____ at _____ | | |
| (Physician's Name) | | (Practice/Facility Name) |
| Phone Number: | _____ | Fax Number: _____ |
| Street Address: | _____ | |
| City: | State: _____ | Zip Code: _____ |

| | | |
|--|--------------|----------------------|
| To Release Medical Information Regarding | | |
| Patient Name: _____ | | |
| Social Security Number: | _____ | Date of Birth: _____ |
| Name of Physician/Facility Receiving the Medical Records: _____ | | |
| Phone Number: | _____ | Fax Number: _____ |
| Street Address: | _____ | |
| City: | State: _____ | Zip Code: _____ |
| Specific Information To Be Released: | | |
| All Medical Records for the following dates of treatment: _____ to _____ | | |

I understand that I may revoke this authorization to release information at any time by providing written notice. Unless I revoke this authorization in writing prior to such time, this authorization shall expire one year from the date of signature. The person who receives the records which this consent pertains may not re-disclose them to anyone without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. This authorization may be relied upon when transmitted by facsimile.

I authorize the authorized medical information to be sent by facsimile (fax) Yes / No

Signature of Patient: _____ Date Signed: _____

Signature of Parent/Legal Guardian: _____

Witness: _____