NEUROSURGICAL ASSOCIATES, INC.
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STEPHEN F. CALDERON, MD
HOWARD LANTNER, MD

Authorization

I, _____hereby authorize Neurosurgical Associates, INC. to make use and disclosures of my protected health information as follows:

1. Description of the Information to be Used or Disclosed.

_____

2. The Name or Specific Identification of Persons or Classes of Persons to Whom Disclosure May be Made.

_____

3. Description of the Purposes of the Requested Use or Disclosure.

_____

4. This Authorization will expire on:

_____

5. I understand that I may revoke this Authorization at any time by providing written notice to Neurosurgical Associates, INC. I understand that I may not be able to revoke this Authorization if Neurosurgical Associates, INC. has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

6. I understand that Neurosurgical Associates, INC. will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

7. I understand that the protected health information disclosed under this Authorization may be subject to redisclosure by the recipient and no longer protected by the federal Privacy Regulations.

I also understand that if the PHI that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, Neurosurgical Associates, INC. may not redisclose that information under Connecticut State Law.

8. I acknowledge that I have carefully reviewed this Authorization and understand its provisions. A copy of this executed agreement will be given to me.

_____
[Date]

_____
[Signature of Person giving Authorization and relationship to Patient, if applicable]