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Release of Protected Health Information Authorization

I, _____ (Date of Birth _____) hereby authorize Neurosurgical Associates of SW CT, PC. to make uses and disclosures of my protected health information as follows:

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

Describe the information using plain language. Be specific.

*Psychiatric records, substance abuse records or HIV- related information
will be release
unless signed below to prohibit releasing this info.*

Psychiatric Records _____
Substance Abuse Records _____
HIV -related information _____

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. Expiration Date or Event. (one year maximum)

This Authorization will expire on:

5. Revocation.

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

6. Services Not Conditioned on Authorization.

I understand that Neurosurgical Associates of SW CT, PC. 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. Redisclosure.

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 protected health information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the may not redisclose that information under Connecticut State Law.

8. Acknowledgement.

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

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

Date

TO BE COMPLETED BY STAFF AT NEUROSURGICAL ASSOCIATES OF SW CT, PC.

9. Identification Verification:

If *known* to staff _____ Staff member to sign

Staff member to date

If *unknown* to staff
Signature on file _____ Driver's license

Other document on file

Staff member to sign

Staff member to date

Any other verification must be documented with a Verification Form. See HIPAA Privacy Officer