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Medical Authorization Form

Patient's Name: _____
(Please Print)

Authorization to release medical information

I hereby authorize my physician to release any information acquired in the course of my examination or treatment to my insurance company or any doctor or hospital I may by referred to.

Should my account be referred for collection after a default, I agree to pay all costs of collection, including a reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

Signature (Patient or Guardian) _____
Date

Payment of Benefits

Authorization to pay benefits to physician: I hereby authorize payment to be made directly to: Neurosurgical Associates of Southwestern, CT PC for any surgical and/or medical benefits, that otherwise would have been payable to me for their services. I am also responsible for payment when current insurance information is not provided to NSA in a timely fashion.

Signature (Patient or Guardian) _____
Date

Disclosure of Medical Information

(List the names of family members, friends, etc. that my call on your behalf)
You are hereby authorized to disclose to the following individual(s), information pertaining to my medical condition, including diagnosis, prognosis, appointments, medications and treatment plan. *(This authorization will continue in force until revoked by me in writing.)* _____

(Initial)

Messages

Neurosurgical Associates of SW, CT, PC has my permission to leave a message on my answering machine.

At home Yes No **At work** Yes No _____
(Initial)