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Fax (203) 792-8193

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 be 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 may call on your behalf)***

You are hereby authorized to disclose to the following individual or individuals, 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*