TRIANGLE NEUROSURGERY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Triangle Neurosurgery, PA:

- to file insurance claims for all services provided to me and I assign payment for those services directly to the provider;
- to release information about me to any referring physician or other provider or to any institution or provider as necessary to provide treatment or diagnosis for me;
- to release information about me as necessary to process claims for payment for services provided to me, including health and liability insurance companies; agencies processing Medicare, Medicaid, or workers' compensation claims, medical benefits plans, case managers or reviewers, or third parties responsible for paying claims for services provided to me.
- to release information about me as necessary to complete disability forms to assist in collecting disability payments payable to me, and to forward required information to disability insurance carriers or agencies processing the claim.

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Triangle Neurosurgery, PA.

I understand the revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that my treatment is not conditioned upon signing this document and that I have the right to refuse to sign this authorization. Until revoked by me, this authorization shall be in effect.

If I have questions about this authorization I understand that I can call Triangle Neurosurgery Medical Records at 235-0222.

_____ _____ / _____/ _____

Patient Signature Date

_____

Printed Name

If the patient's representative signs: I confirm that I am legally authorized to speak on the patient's behalf regarding disclosure of information about the patient.

_____ _____ / _____/ _____

Patient's Representative Signature Date

_____

Printed Name