

NEUROSURGICAL ASSOCIATES, INC.

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STEPHAN C. LANGE, MD
STEPHEN F. CALDERON, MD
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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]