

**NEUROSURGICAL ASSOCIATES, INC.**

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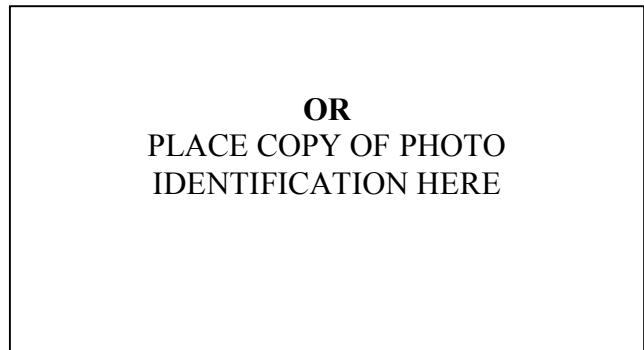
**Verification Form**

Neurosurgical Associates, INC. must verify the identity of a person requesting protected health information ("PHI") and the authority of the person to obtain the PHI whenever Neurosurgical Associates, INC. does not already know the identity or authority of the person.

Pursuant to this requirement, please provide Neurosurgical Associates, INC. with the following information:

**IDENTIFICATION**

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Signature: \_\_\_\_\_



or attach copy of photo I.D. or business card

**AUTHORITY**

Please state the reason for the request and the basis for your authority to make the request. Attach any relevant documents which relate to your request.

\_\_\_\_\_  
\_\_\_\_\_

I hereby certify, under penalty of law, that the foregoing is true and correct and that I am authorized to have access to the requested protected health information.

Authorized & Accepted By:

\_\_\_\_\_  
Signature of Person Making Request

\_\_\_\_\_  
On Behalf Of Neurosurgical Associates, INC.

\_\_\_\_\_  
Date