The Metropolitan
Neurosurgery
Group LLC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ Today's Date: ______________

I request and authorize **Metropolitan Neurosurgery Group LLC** to release healthcare information of the patient named above to:

Name: ________________________________

Address: ________________________________

City: ______________ State: Zip Code:

Phone: ______________ FAX: ______________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

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☐ All healthcare information

☐ Other: ________________________________

Notice: The unauthorized disclosure of mental health information violates the provisions of the State of Maryland Health General Article, Subtitle 3 - Confidentiality of Client Records. Disclosure may only be made pursuant to valid authorization by the client or as approved by the Laws and Regulations of the State.

☐ Yes ☐ No I understand if I refuse to sign this consent the information will not be released. In addition, I am aware any and all consents may be revoked by my when a revocation is submitted in writing; any such revocation shall have no effect on disclosures made prior thereto.

Patient Initial: ________ Date Signed: ______________

☐ Yes ☐ No I authorize the Metropolitan Neurosurgery Group to furnish information in its possession relative to my diagnosis, treatment or account status to other treating physicians, other treating healthcare providers and healthcare institutions who I specify, and to my insurance carriers and their agents.

Patient Signature: ______________________ Date Signed: ______________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.