NEURO ORTHO NYC

ONE TEAM

Multiple Specialties

Joshua Adjei, MD
Murat Cosar, MD
Marc Dyrszka, MD
John Grant, MD
Mehdi Kazmi, MD
Simon Morr, MD
John Morrison, MD
Deborah Petrucci, MD
Nicholas Post, MD
Jay Reidler, MD
Yigal Samocha, MD
David P. Trofa, MD

Patient Authorization

DATE _____

RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Neuro Ortho NYC to release my records and any information requested to the following individuals.

1. _____ RELATION TO PATIENT _____

2. _____ RELATION TO PATIENT _____

PHONE CALLS & MESSAGES

Please check all that apply.

- ☐ I authorize you to speak with _____
- ☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
- ☐ I authorize you to leave a message with anyone who answers the phone
- ☐ Messages may only be left with _____

PATIENT NAME (PLEASE PRINT) _____ DATE _____

PATIENT SIGNATURE _____

IF NOT SIGNED BY PATIENT, RELATIONSHIP _____

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