CENTER FOR NEUROSURGICAL AND SPINAL DISORDERS

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative regarding:

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

□ Only the following types of information:

_____
_____
_____

The above medical information shall only be released to the following persons:

Family Member / Personal Representative	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)
□ Until revoked in writing.
□ Until _____, 20____

I know that I am entitled to receive a copy of this agreement.

_____ _____
Print Name of Patient or Legal Guardian Date of Birth

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Witness

_____ _____
Signature of Witness Date