Patient Consent To Release Information

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for **H.I.P.P.A.** we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory/pathology results to the family members indicated below. This consent form will not allow *South Florida Neurosurgery* to release any other information to these family members.

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 *South Florida Neurosurgery* to release my medical information/results and reports to the following individuals.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Signature of Patient/Guardian: _____

Authorization to Leave Messages with Household Members/Answering Machine
From time to time it is necessary for representatives of *South Florida Neurosurgery* to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss procedure results, or to ask a patient to call *South Florida Neurosurgery* regarding an issue or concern. At no time will a representative of *South Florida Neurosurgery* discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

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

Signature of Patient/Guardian: _____ Date:_____