HAYNES NEUROSURGICAL GROUP, P.A.
801 PRINCETON AVENUE SOUTHWEST
POB 1 SUITE 310
BIRMINGHAM, AL. 35211
Phone: (205) 787-8676 Fax: (205) 785-7944

Receipt for HIPPA Privacy Notice and Authorization to Obtain or Release Medical Information

Name: _____ Date of birth: _____
SSN: _____ Date of request:_____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Haynes Neurosurgical Group, P.A. in writing, but if I do, it will not have any effect on uses of disclosures prior to the receipt of the revocation.

I hereby authorize Haynes Neurosurgical Group, P.A. to use, disclose health information as follows:

Release to: _____ Relation to patient: _____
(name)
Address: _____ Phone number: _____

Release to: _____ Relation to patient: _____
(name)
Address: _____ Phone number: _____

PLEASE NOTE THAT BY CHECKING ANY BOX BELOW MAY RESULT IN THE STAFF OF HNS LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE AT THE NUMBER REQUESTED BY YOU.

YES NO The physicians and staff of Haynes neurosurgical Group may confirm appointments to my answer machine at the number provided on my Patient Information Sheet.

YES NO The physicians and staff of Haynes neurosurgical Group may release information to my pharmacy without prior authorization in order to allow call-in of a prescription.

SPECIAL INSTRUCTIONS:

_____
_____
_____

My signature below is acknowledgement that I have received a copy of the Haynes Neurosurgical Privacy Notice and that I agree to the conditions stated in the notice:

Patient Signature: _____Date:_____