SURGIMON

Authorization for Release of Protected Health Information

I authorize Surgical Neuromonitoring Associates, Inc. (Surgimon). to release information from the record of:

Patient Name _____ Birth Date _____ SSN/MRN _____ as described below to:

Facility/Person to receive records _____ Phone _____ Fax _____

Street _____ City _____ State _____ Zip _____

Please provide the patient's address (if different from above info) & phone number below:

Patient Address _____ Patient Phone Number _____

Records are requested for the purpose of *(Please check one)*: ☑ Continuing care/Medical Facility ☑ Legal ☑ Personal Use ☑ Insurance ☑ Other:

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released **and** date(s) of service (check all that apply):

☐ Inpatient - Dates:

☐ Same Day Surgery - Dates:

2. Specific information to be released (check all that apply):

☐ IONM Reader/Tech Reports ☐ Case Notes

☐ Consent for Services ☐ Other: *(specify)*

☐ Assignment of Benefits

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.**

If applicable, specify other expiration date/event here:

Date of Signature _____ **Signature of Patient** (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) _____

Date of Signature _____ **Signature of Authorized Representative** _____
*Appropriate paperwork required

☐ Parent or Legal Guardian ☐ Power of Attorney

☐ Next of Kin of Deceased ☐ Executor of Estate

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date _____ **Witness #1** _____ **Date** _____ **Witness #2** _____

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for thereproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.