SURGIMON

Patient Label

Assignment of Benefits and Authorization For The Use And Disclosure Of Protected Health Information

Patient Name: _____ Date of Service: _____

Assignment of Benefits

I authorize payment of benefits, including benefits of any applicable insurance policy or employee benefit plan or healthcare plan, for Intraoperative Neurophysiological Service(s) to Surgical Neuromonitoring Associates, Inc. or to its retained physician service providers, Surgical Neuromonitoring Associates, PLLC and Surgimon, LLC (Surgical Neuromonitoring Associates, Inc., Surgical Neuromonitoring, PLLC, and Surgimon, LLC are herein referred to as "Provider").

Authorization to Release Information

I consent to and authorize any other person or entity that holds any of my patient Protected Health Information ("PHI") to disclose all my PHI in any form (including oral, written or electronic) to Provider or any person or entity designated by Provider to receive my PHI for purposes of facilitating my care and treatment. For the purposes of this Authorization, PHI may include, but is not limited to, the following:

- All medical records, including, but not limited to inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, subjective and objective complaints, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or healthcare providers.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram & cardiac catheterization reports.
- All radiology films; mammograms; myelograms; photographs, CT scans; bone scans, pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens; cardiac catheterization videos; and echocardiogram videos.
- All prescription and pharmaceutical records, including, but not limited to: NDC numbers and drug information handouts/monographs.
- All correspondence to/from/about me, memos, office notes, narrative summaries, and telephone messages.
- All billing records, including, but not limited to all statements, invoices, itemized bills, and insurance records.
- All documents related to the amendment of any record requested.

I hereby authorize Provider to release any information necessary to my health benefit plan or to its administrator regarding my medical procedure. I further authorize the Providers and their authorized representatives to (1) discuss my personal health information with the health insurer, employee benefit plan, or healthcare plan, or their authorized representatives; (2) file any necessary appeals, complaints, or claims with my health insurer, employee benefit plan, or healthcare plan, or their authorized representative; and (3) obtain copies of my health insurance policy, employee benefit plan, or healthcare plan.

I understand that this authorization may be revoked at any time, except to the extent already acted upon, by giving written notice to Provider. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. I understand that Provider may redisclose this information, and if re-disclosed, the information would no longer be protected by federal privacy rules and regulations. Any facsimile or copy of this authorization authorizes the release of the records requested herein.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy, employee benefit plan, or employee healthcare plan: (1) the right and ability to act on my behalf in connection with any claim, appeal, right, or cause of action, including without limitation, any claim that may be brought pursuant to ERISA, that I may have under such insurance or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy or benefit plan, including but not limited to the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under law, to claim on my behalf, such benefits, claims, or reimbursement and any other applicable remedy.

Certification

I certify that I have read and understand the contents of this form. If I am not the patient, I certify that I am authorized by the patient to sign this form and accept its terms.

Signed:

_____ _____

Patient (If patient is a minor or unable to sign, please complete the following) Date

_____

Authorized Representative

_____

Relationship to Patient