FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

Specializing in the treatment of spinal meningeal cysts

HIPAA RELEASE OF INFORMATION

PATIENT NAME:		DATE OF BIRTH:
PATIENT ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
EMAIL:		

□ In accordance with Feigenbaum Neurosurgery Privacy Practices, I hereby authorize Feigenbaum Neurosurgery to communicate with the following people:

NAME:	RELATIONSHIP TO PATIENT:
PHONE NUMBER:	

NAME:	RELATIONSHIP TO PATIENT:
PHONE NUMBER:	

NAME:	RELATIONSHIP TO PATIENT:
PHONE NUMBER:	

This authorization will remain in effect until you send us written notice of your desire to change and/or revoke the authorization.

PATIENT/REPRESENTATIVE SIGNATURE:	DATE:
RELATIONSHIP TO PATIENT: □ Parent □ Guardian □ Other	

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