



SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES

SOUTHWEST FLORIDA REHAB & PAIN MANAGEMENT ASSOCIATES

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Please Check One of the Following:

_____ I REQUEST THAT ALL OF MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER FRIENDS OR FAMILY.

OR

_____ I GIVE MY PERMISSION TO THE EMPLOYEES OF SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES AND/OR SOUTHWEST FLORIDA REHAB AND PAIN MANAGEMENT TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Southwest Florida Neurosurgical Associates and Southwest Florida Rehab and Pain Management to call you at any phone number you provide to us. Please let us know what type of message we may leave on your answering machine/voicemail by answering the following questions by circling **YES** or **NO**.

When we contact you by calling you at any telephone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? **YES** or **NO**

If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your telephone when we are contacting you to remind you of an appointment at our office.*****

I understand I may revoke or change this consent at anytime by filling out another consent form to replace this one.

Patient/Guardian/or Legal Representative Signature

Date

Printed Name if not signed by Patient

Relationship

Internal Use Only: Please post the above information in the patient's off-bill comments.

Date Received: _____ Posted By: _____

DATE REVOKED/CHANGED _____

If revoked/changed see new consent form