Metropolitan Neurosurgery

HEALTH INFORMATION/ MEDICAL RECORDS ACCESS PERMISSION FORM

PROTECTED HEALTH INFORMATION

Please indicate below any persons that are permitted to have access to your protected medical information (labs, medical records, x-ray reports, billing records, etc.)

- o **I do not wish to list any individuals** **Date:**_____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

Patient Name (PRINT): _____

Signature: _____

3-4-20