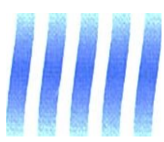

EMAS
SPINE & BRAIN SPECIALISTS
EXCELLENCE IN NEUROLOGIC CARE

MARK EMAS MD
ANIKA GOEL MD
CHARLES POPE PA-C
BILL FAUNCE PA-MPAS

BRADLEY TRAN MD
OLGA GUSKOVA PA-C
BONNIE BROGDON PA-C

Health Care Status Authorization Form

I, ____DOB: ___/____/____
(Patient Name)

give authorization to Emas Spine and Brain Specialist (Neurology Partners) to release information concerning the status of my health care, including making and cancelling appointment, refilling medications, and discussing my medical with any staff member regarding any and all medical issues which may arise while under the care of Emas spine and Brain Specialist (Neurology Partners).

Below is a list of relatives/ friends who are authorized.

Name	Relationship	Telephone #

I understand I may revoke this authorization at any time. I Understand it is my responsibility to contact the office in advanced if I wish to have any information excluding from the persons named above.

____
Patient Signature

_____/_____/_____
Date

____
Witness