



EMAS

SPINE & BRAIN SPECIALISTS
EXCELLENCE IN NEUROLOGIC CARE

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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.

<u>Name</u>	<u>Relationship</u>	<u>Telephone #</u>

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