ARIZONA NEUROSURGERY
& SPINE SPECIALISTS, P.C.

PATIENT DESIGNATED INDIVIDUAL AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that identity of designated parties must be verified before the release of any information.

Authorized Designees & Physicians:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

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