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AUTHORIZATION TO DISCUSS & RELEASE CONFIDENTIAL PATIENT INFORMATION WITH FAMILY AND FRIENDS

I, _____ hereby authorize Dr. _____,
and Neurosurgical Associates, P.C. to discuss my medical and / or financial information with the following
person and / or persons:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____

Date: _____

Witness: _____