Authorization Form

Providence Neurosurgery SW Washington
615 Lilly Rd NE #220 ✷ Olympia, WA 98506
(360) 486-6150 ✷ fax (360) 486-6155

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS
THIS DOCUMENT WILL BECOME PART OF YOUR MEDICAL RECORD

Authorization for Treatment

I hereby authorize the administration of all procedures, medication, and anesthetics that may be considered necessary or advisable in the judgment of the Providence Neurosurgery Provider..

Insurance Assignment

I hereby assign to Providence Neurosurgery all payments due by my medical plan or other liable insurance carrier for any and all services furnished by Providence Neurosurgery to me or my dependents for whom I am financially responsible. I understand that I am responsible for payment for those services.

Authorization to Release Information

I hereby authorize Providence Neurosurgery to release necessary medical information to any insurance carrier, or their representatives, for the purpose of processing Providence Neurosurgery's claims for payment for services rendered to me or my dependents.

Confidentiality of Records

I understand that Providence Neurosurgery will maintain confidentiality of my medical record including the physical chart, electronic records, and billing/account information. Providence Neurosurgery uses electronic media to store certain patient information including secure portions of the Internet.

I certify that I have read, understand and agree with the above statement. I understand that this authorization is valid for one (1) year unless revoked in writing and that a copy is as valid as the original.

I, _____ have read and agree with the above statements.
Please print name and relation to patient

_____	_____
Signature	Clinic Representative
_____	_____
Date	Date
_____	_____
Patient Name	Patient Date of Birth

7282-13-NH-01 (5/93)