Great Lakes Neurosurgical Associates
Release of Information for Participation in Healthcare

Patient's Name (First/MI/Last) _____

Date of Birth (MM/DD/YYYY) _____

I designate the following person(s) as participants in my healthcare and allow him or her the right to obtain healthcare information about myself, verbal or written. By signing this form, I release Great Lakes Neurosurgical Associates from any liability of any nature in connection with its release of my personal health information to the person(s) designated below and any use, misuse or secondary release of such information by the person(s) named below. This authorization will remain effective until revoked by myself in writing. If I do decide to revoke this authorization, it will not affect the actions taken prior to revocation. My treatment cannot be conditioned on whether or not this authorization is signed. This authorization may be changed or updated at any time. My healthcare provider(s) at Great Lakes Neurosurgical Associates will only provide the necessary and pertinent information to the following person(s):

	Name	Relationship	Phone Number
1.			
2.			
3.			
4.			

Additionally, I will allow messages from Great Lakes Neurosurgical Associates to be left on my home or cell phone voice-mail if I am unavailable to answer the call: □ Yes □ No

Patient Signature _____ Date _____

If someone other than patient:
Legal Rep Signature _____ Date _____
□ Parent of Minor □ Legal Guardian □ Other _____

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If you need help or have questions about this form, contact our office at 414-488-1802