Vero Neurospine

1040 37th Place, Suite 101, Vero Beach, FL 32960, (772)205-3345(phone), (772)205-3346(fax)

COMMUNICATION OF MEDICAL INFORMATION

NAME: _____ **DATE OF BIRTH**_____

RELEASE OF MEDICAL INFORMATION

BY SIGNING BELOW, I AUTHORIZE VERO NEUROSPINE TO DISCLOSE MY RELEVANT MEDICAL AND BILLING INFORMATION TO:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE _____ DATE _____

We ask that if you have any changes in this request, that you please inform the receptionist.

REQUEST FOR ELECTRONIC COMMUNICATIONS

I request that the following communications from the practice be delivered to me by the electronic means selected. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals.

TYPE OF COMMUNICATION:

_____Appointment reminders _____Surgical scheduling _____Other_____

METHOD

_____Email Preferred Email Address: _____

_____Text Number: _____

_____Phone Number: _____

My signature below is an agreement that I am willing to accept that risk that personal health information could be received by unauthorized individuals through requested electronic means of communication and will not hold Vero Neurospine responsible should such incident occur.

PATIENT SIGNATURE _____ DATE _____