The Metropolitan Neurosurgery Group LLC
1010 Wayne Avenue, Ste. 420, Silver Spring, MD 20910
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DESIGNATION FOR RELEASE OF MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

It is a physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPPA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc., without an authorization.

The Metropolitan Neurosurgery Group, LLC, (MNG) realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. This form is an aid to your surgeon in making a determination on disclosing such information. MNG wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition should we be contacted. To enable that, we would ask that you complete the form listed below.

Please note the following points:

- ☐ Only one person can be designated for this role.
- ☐ The designation is valid until you cancel it in writing, no via phone, no faxed, no emailed form.
- ☐ This designation does not grant legal rights for others to make medical decisions on your behalf.
- ☐ If you designate no one, MNG will not release information to any family member or friend or legal representative.

Designation Statement

I, _____, designate the following person to be able to speak to The Metropolitan Neurosurgery Group, LLC, surgeons, or other staff member, should it be necessary, on my behalf. I hereby give permission to The Metropolitan Neurosurgery Group, LLC, through its surgeons and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release The Metropolitan Neurosurgery Group, LLC, its surgeons and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person:_____

Relationship: Phone Number:_____

Patient Name: Signature:_____

Witness Name: Signature: _____ Signature_____Date:_____

I decline to designate another person to speak with my physician or clinical staff.

Patient Signature:_____Date:_____

Witness:_____ Date:_____