NEUROLOGICAL SURGERY, P.C., a/k/a NSPC
PATIENT COMMUNICATION CONSENT FORM

Patient Name: ____________________
Date of Birth: ____________________

I agree to allow NSPC to contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/do not authorize NSPC to leave messages for me when I am unavailable as indicated below.

CHECK TO CONFIRM APPROVAL OF METHOD	METHOD	NUMBER/ADDRESS	MESSAGES (YES OR NO)
_________	Home Phone	( )_________________	☐ YES ☐ NO
_________	Cell Phone	( )_________________	☐ YES ☐ NO
_________	Work Phone	( )_________________	☐ YES ☐ NO
_________	Alt. Phone	( )_________________	☐ YES ☐ NO
_________	Email	( )_________________	☐ YES ☐ NO

I authorize NSPC and medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else not otherwise authorized under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

NAME	RELATIONSHIP TO PATIENT	CONTACT INFORMATION

EMERGENCY CONTACT ONLY:
NAME: ____________________________________ PHONE NUMBER: __________________________

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

____________________________________ ________________________
Patient Name Printed Date

____________________________________ ________________________
Patient/Authorized Signature Relationship to Patient