Southern California
Center for Neuroscience and Spine

Patient Authorization

"Health Insurance Portability and Accountability Act" (HIPPA)

- Please print the telephone numbers where you want to receive calls or information about your appointments, labs or other health care issues that would come directly from our physicians or staff members:

  Home Phone: (_____) _____

  Work Phone: (_____) _____

  Cell Phone: (_____) _____

- Can confidential messages (ex: appts., labs or referrals) be left on your home answering machine or cell phone voicemail:

  Yes_____ No_____

- Please provide an email address if you would like any news, updates or changes in regard to our office:

  Email: _____

- Please list family members or other person, whom we may inform about your general medical condition and/or diagnosis:

  Name:_____ Relationship:_____

  Name:_____ Relationship:_____

  Name:_____ Relationship:_____

The information on this authorization is good for the period of one year from the date it is signed and agreed to by the patient:

Patient Name:_____ Date_____

Patient /Guardian Signature:_____