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I have read and understand the Notice of Privacy Practices of Delaware Neurosurgical Group, P.A. and its physicians.

_____ _____
Signature Date

Other than myself, the following are persons I authorize Delaware Neurosurgical Group to talk to regarding my medical information:

Relationship to Patient	**Name**
____ Spouse	_____
____ Significant Other	_____
____ Child	_____
____ Parent	_____
____ Guardian	_____
____ Sibling	_____
_____	_____
_____	_____

If we need to contact you, do we have your permission to leave a message on your voicemail or with a person who answers your phone, whether at home or work? Please check below:

At home YES _____ NO _____

At work YES _____ NO _____

Print name _____

Signature _____ Date _____