

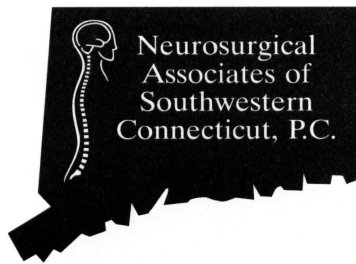
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Danbury, CT 06810-4032  
Phone: (203) 792-2003  
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Chart: \_\_\_\_\_

**To Be Completed By Patient**

**Patient's Name:** \_\_\_\_\_  
(Please Print)

**Authorization to release medical information**

I hereby authorize my physician to release any information acquired in the course of my examination or treatment to my insurance company or any doctor or hospital I may be referred to.

\_\_\_\_\_  
Signature (Patient or Guardian)

Should my account be referred for collection after a default, I agree to pay all costs of collection, including a reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

\_\_\_\_\_  
Date

**Payment of Benefits**

Authorization to pay benefits to physician: I hereby authorize Payment to be made directly to: Neurosurgical Associates of Southwestern Connecticut, CT PC, for any surgical and/or medical benefits, that otherwise would have been payable to me for their services. I am also responsible for payment when current insurance information is not provided to NSA in a timely fashion.

\_\_\_\_\_  
Signature (Patient or Guardian)

\_\_\_\_\_  
Date

**Emergency Contact Person** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

**Disclosure of Medical Information (List the names of family members, friends, etc that may call on your behalf or we can speak to on your behalf)**

You are hereby authorized to disclose to the following individual or Individuals, information pertaining to my medical condition, including Diagnosis, prognosis, appointments, medications and treatment plan.  
(This authorization will continue in force until revoked by me in writing.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Initial

**Messages**

Neurosurgical Associates of Southwestern Connecticut, CT PC has my permission to leave a message on my answering machine :

At Work: \_\_\_ Yes \_\_\_ No  
At Home: \_\_\_ Yes \_\_\_ No  
Cell : \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
Initial