Surgical Associates, PC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Full Name of Patient: _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Birth Date: _____ SSN: _____

Previous Name: _____

REQUESTING INFORMATION FROM:

I authorize **Surgical Associates, PC** to disclose the following protected health information ("my protected health information") from the time period beginning on _____ and ending on _____: (please fill in dates of records being requested)

Please initial		Please initial	
___	Operative Procedure _____	___	Lab Results/Pathology _____
___	X-Ray Reports _____	___	Consult/Progress Notes _____
___	History & Physical _____	___	Other (specify) _____

to _____ Phone: _____
(Name of Individual(s) or Agency) Fax: _____

Address: _____ City: _____State: _____ Zip: _____

for the following purpose(s)

___ At the request of the individual ___ Other (specify) _____

By signing this authorization, I understand that I am authorizing the Provider to use or disclose my protected health information (PHI) to Surgical Associates, PC for the purpose(s) I have identified. I understand I can revoke this Authorization in writing and doing so will stop future use or disclosure of my PHI; but I understand that Provider can act on this Authorization until either I revoke my authority in writing or until the expiration date in this authorization. If I want to revoke this Authorization, I will send my written notice of revocation to Provider.

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that if I should decide not to sign this Authorization there will be no retaliation from Provider nor will there be any effect on my treatment or payment for services Provider provides.

I understand I can see and copy my PHI as described in Provider's Notice of Privacy Practices Policy. I understand Provider cannot control any further disclosure of my PHI by those who received it after it is disclosed as allowed by this Authorization, and that my PHI may not be subject to continued protection under federal law once it is received by the recipient.

I understand that I can request a copy of this Authorization after it is signed. I understand that there may be a charge for copying records.

Unless I indicate at an earlier time, this Authorization expires twenty-four (24) months from the date I sign. _____

*** Patient or Guardian Signature:** _____Date: _____

If this authorization is signed by a parent or legal guardian complete the following:

Name: _____Relationship to Patient: _____

Witness _____ Date: _____

*This signature MUST be that of the patient or Guardian

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