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AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Full Name: _____DOB: _____

Maiden/Previous Name(s): _____SSN: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____

Release From:

_____
(*Name of Individual or Agency)*
Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

Release To:**SURGICAL ASSOCIATES, PC**for the following purpose (check one):

___ at the request of the individual ___ other (specify) _____

Information to be Released/Disclosed (check all that apply):

___ Operative Report ___ Lab/Pathology Results _____
___ Consult/Progress Notes ___ X-Ray/ImagingReports _____
___ History &Physical ___ Other _____

From Dates of Service Starting on:_____and Ending on:_____
(Month/Day/Year) *(Month/Day/Year)*

I Understand the Following:

- Without my express revocation, this authorization will automatically expire 24 months from the date signed below, unless I request an expiration date less than 24 months.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by the Privacy rule.
- A signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided.
- I can request a copy of this authorization after it is signed.

Patient/Guardian Signature:_____**Date:** _____

If this authorization is not signed by the patient complete the following:
Printed Name: _____Relationship to Patient: _____