SURGERY ASSOCIATES, P.A.
Authorization for Release of Information

For information about how your medical information may be used or disclosed, please see Patient Privacy Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer. The Notice is also posted at Surgery Associates, P.A.'s office.

- YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED
- YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (*such as enrollment in research study or examining you to create a report for your attorney*).
- WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARTCH-RELATED TREATMENT.
- WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

THIS AUTHORIZATION IS VOLUNTARY

I, ____________________________ , Date of Birth _______________ SSN ______________________
do hereby authorize *Surgery Associates, P.A.* to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse the released information may no longer be protected by federal privacy regulations.

I authorize release of information from my medical record (as outlined below and initialed):

X________ Complete medical record that may contain treatment notes regarding radiology, pathology (including AIDS/HIV test results, genetic testing information, immunization procedure(s)), alcohol and drug abuse records, psychological or psychiatric conditions, if any, protected by Federal Confidentiality Rules 42 CFR Park 2, and other common medical record documentation made by the physician, nurse, or other ancillary personnel for the eintire time I was treated by this practice.

OR

For information collected/services described below and provided during the time period of _________________.

Description of records to be released ____.

To the following ____.

For the purpose of ____.

I understand that I may withdraw my authorization in writing to the Privacy Officer at any time except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire one *(1) year from this date.* I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

* A Copy of this authorization is as valid as the original.
* I authorize my personal health information or billing records to be released by facsimile./email

X ______________________________________ ________________________
Signature of patient or patient's representative Date
(Form MUST be completed before signing)

X ______________________________________ ________________________
Witness Date

Printed name of patient's representative ______________________________________
Description if the Representative's authority to act for the patient ____________________
Relationship to the patient ____

This form does not have to be completed to release information for treatment or healthcare operations except when the information to be released contains confidential details as listed above, privileged categories or certain research information.

SA - 515 (Revised 04/06)