



Center of Surgical Specialists, P.C.
Advanced Knowledge. Expert Care.

Authorization to Use or Disclose My Health Information

Patient name: _____ Previous name: _____

Date of birth: _____ Social Security Number: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

All my health information maintained by the above named practice

(Circle include or exclude for each of the following)

Include or Exclude: My health information related to drug abuse

Include or Exclude: My health information related to alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

At my request,

Other (specify) _____

This authorization ends: on (date) _____

When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study. or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization by submitting a written letter to the office. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature _____ Date _____ Time _____

Printed Name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative, etc.) _____