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.)