AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I authorize Surgical Advanced Specialty Center to Release to:
Person or Organization:
Address:
Phone:
Fax:

Information/Copies from the medical records on:
Patient Name:
Date of Birth:
Social Security Number:

Dates of service:

Information to be released:

This information is being released for the following purpose:

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180 days) from the date of my signature, unless in writing here:

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations

To The Party Receiving This Information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Is so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENTS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Signature of Patient of Legally Authorized Representative:

Signature

Relationship to Patient:

Witness Signature:

Signature