AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, the GATEWAY SURGERY CENTER may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

I, _____, hereby authorize the use of the following health information:

CHECK ONE:
Pickup__Mail__Fax__Email__to:

Release to:
(Print/Type Name & Address)

_____

_____

_____

Email: Fax:

Patient/Subject of Information:
(Print/Type Name & Address)

_____

_____

_____

Date of Birth: _____

Information to be Released:

___H&P	___O.R. Anes. Notes	___EKG	___MRI films
___O.R. Dictation	___PACU Nurse's Notes	___Lab Reports	___MRI report
___Doctor's Progress Notes	___RC Nurse's Notes	___X-Ray Reports	___Other _____
___Discharge Summary	___Discharge Instructions	___Pathology Reports	

(If you are requesting the disclosure of information to yourself, you may write "any and all information" or "full medical chart." Such broad requests will not be honored if the requested disclosure is to a third party.)

I understand the above requested information may contain sensitive medical information, such as information regarding HIV/AIDS status, venereal disease, tuberculosis and other infectious diseases, pregnancy status, mental illness, addiction, and other sensitive information.

( ) I agree to the disclosure of above specified records without any modifications
( ) Please censor the above requested disclosure as follows: _____
_____

Intended Purpose:

_____

_____

(If you are requesting the disclosure of information to yourself, you may leave this section blank or write "at the request of the individual." If the requested disclosure is to a third party, you must state the purpose.)

Important Notices:
I understand that once the requested information has been released pursuant to this authorization, GATEWAY SURGERY CENTER cannot guarantee the continued privacy of the information. The recipient may not be subject to federal and state laws that protect the privacy of health information and might re-disclose the information to additional parties.

I understand that I can revoke this authorization at any time by signing the revocation section of this form and returning it to GATEWAY SURGERY CENTER. GATEWAY SURGERY CENTER will honor such revocation as soon as GATEWAY SURGERY CENTER receives it except to the extent GATEWAY SURGERY CENTER, or other persons allowed to act under the authorization, have already acted in reliance on this authorization.

This authorization will expire once the information requested has been released and received by the designated individual or third party.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____
Date Signature of Patient or Personal Representative

_____
Relationship to Patient

For Office Use Only: ***Date(s) of Service*** ***Acct#***

☐ *Copy provided to Patient/Personal Representative*

REVOCATION SECTION

I hereby revoke this authorization

_____ _____
Signature Date