

## Authorization For Disclosure of Protected Health Information

PATIENT NAME:		DATE OF BIRTH:		
Address:		Phone:		
You may disclose the fol	owing health care information	ı (check AL	L that apply):	
<ul> <li>Current Medical</li> </ul>	Records information (clinic not ce, including 12 months prior to	tes, radiolo	gy reports, MRI report	s, operative notes, etc. for
Health care info	ormation (notes/reports) in m	ny medical	record related to th	e following treatment or
Health care infor	mation in my medical record (n	otes/repor	ts) for the date (s):	
<ul> <li>X-ray images (on</li> </ul>	CD)			
MRI images (on C	D)			
Billing information	n			
Other - specify in	formation & date(s):			
	ds information (clinic notes, ra			
You may use or disclose apply) HIV (AIDS Virus) Sexually Transmitted	-		<ul> <li>esting, diagnosis, and treatment for (check all that</li> <li>Psychiatric disorders / mental health</li> <li>Drug and/or alcohol use</li> </ul>	
You may disclose this he				
Name (or title) and organ			Ctata	
			State:	Zip:
At my request	ization (check all that apply):			
This authorization expire	<b>2S</b> : (if disclosure is to a financial institution	on or employe	of the natient for nurnoses o	ther than payment, then as to those
-	es 90 days after signed, unless renewed.)		-, pacient jer parposes e	
On date:				

When the following event occurs:

**My Rights** – I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider. If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of patient

Relationship (parent, legal guardian, personal representative)