SURGICAL ASSOCIATES OF COLLIN COUNTY

4001 W. 15th Street, Suite 335 Plano, Texas 75093
Phone: 972-596-5225 Fax: 972-596-2684

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical records of:

Patient Name _____ Date of Birth _____ Social Security Number _____

I authorize the following individual or organization to disclose the above named individual's health information and medical records including those received from other facilities and health care providers:

_____ Address: _____.

This information may be disclosed to and used by the following individual or organization:

_____ Address: _____.

Please release the following: _____.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Initials required: _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless other wise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about discloser of my health information, I can contact Joyce Snell, Privacy Officer for Surgical Specialists of Plano at 972-596-5225.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative Signs Above) Witness

Complete only if information is to be released directly to patient:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Surgical Specialist of Plano liable of any misinterpretation of information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative Sign Above) Witness
Date request completed_____ # of pages copied_____