PROTECTED HEALTH INFORMATION Authorization to Release Form

AmSurg Center System Policies

agress	The ir Name Addre	is	Patie ersons					
	The ir Name Addre	nformation is to be disclosed to the following permeters: ess: ose. The purpose of the use or disclosure is: At the request of the patient	ersons	or organizations:				
	Addre	ess:ess:ess:ess:essesse. The purpose of the use or disclosure is: At the request of the patient						
	Purpo	ose. The purpose of the use or disclosure is: At the request of the patient						
	Purpo	ose. The purpose of the use or disclosure is: At the request of the patient						
		At the request of the patient						
j	If the purpose is for marketing, will the Center receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around							
		The following medical records:		(sere dates).				
		☐ Discharge summary		Progress notes				
		☐ Lab results		Photographs, videotapes, or other images				
		History and physical exam		Mental or behavioral health records				
		Consultation reports		Psychotherapy notes				
		☐ X-ray reports		Genetic test results				
		☐ HIV/AIDS test results and treatment		Entire medical record				
		Alcohol and drug treatment recordsOperative record		Summary of treatment Other (specify):				
		The following billing and payment informati	nation:					
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Ē]	Other information:						
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However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.

5. <u>Expiration</u>. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

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Last Reviewed: 5/1/2009

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6.	<u>Redisclosure</u> . I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.								
7.	Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Center will not condition treatment on whether I sign this Authorization.								
8.	Certification. I certify that I am (check whichever applies):								
	the patient, and the identification that I have provided is true and correct. the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of								
Signed	this day of	, 200 <u> </u> .							
		Signature:							
		Print name:		_					
		Address:							
				_					
		Phone No:		_					
				_					
Witne	ss:								
Print i	Name:								
Date:	(OI		ETAINED BY THE REQUESTING PARTY)						
	ffice Use Only:		Expiration date:						
How v	was identity verified?was authority verified?:		Copy made? ☐ Yes ☐ No Copy made? ☐ Yes ☐ No						
			Title:						
	2.42		Last Revi	ewed: 5/1/2009					