PROLIANCE SURGEONS®

Authorization for Proliance Surgeons, Inc., P.S. to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my medical record
☐ Health care information in my medical record relating to the following treatment or condition:
_____
☐ Health care information in my medical record for the date(s): _____
☐ Other (e.g., X rays, bills), specify date(s):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____
_____
Address: _____ City: _____ State:_____ Zip: _____

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ other (specify):
_____
☐ check only if practice requests the authorization for marketing purposes
☐ check only if practice will be paid or get something of value for providing health information for marketing purposes

☐ **This authorization ends:** *(If disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*
☐ on (date): _____
☐ when the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already 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. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the practice. Or
- Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)