THE CENTER FOR
MINIMALLY INVASIVE
SURGERY

PATIENT NAME	ACCOUNT NUMBER	DATE OF BIRTH

PATIENT ADDRESS

I HEREBY AUTHORIZE THE FACILITY NAMED ABOVE TO DISCLOSE "PROTECTED HEALTH INFORMATION" TO:

_____

PERSON/ORGANIZATION/FACILITY/HEALTHCARE PROVIDER NAME

_____

STREET ADDRESS

_____

CITY/ZIP CODE

CHECK TYPE OF INFORMATION AUTHORIZED TO BE DISCLOSED

NOTE--Unless the appropriate box is checked, the Facility will only disclose records regarding care and treatment provided in the Facility by Facility staff or its affiliated health care providers.

- ❑ All records/all treatment by all providers/all facilities
- ❑ All records/all treatment from this Facility only
- ❑ Billing Records
- ❑ Physician Progress Notes
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Other:_____

(*Specifically describe the information or date(s) of care/treatment to be disclosed)*

- ❑ Physician Orders
- ❑ Nurses' notes
- ❑ Imaging/Radiology Reports
- ❑ Operative Report
- ❑ Lab/Test Results Only

Reason for request (optional)_____

- ✓ I understand that I may revoke or cancel this authorization at any time.
- ✓ I understand that any information/PHI released previous to this revocation or cancellation has been released in good faith and is now in the records of a healthcare entity or provider as previously authorized.
- ✓ I understand that PHI that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- ✓ I also understand that the Facility is not responsible for any misuse or disclosure made by a third party to whom I have authorized release of the PHI.
- ✓ I understand that I have the right to request or inspect or copy my PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- ✓ I understand that I can refuse to complete this authorization.
- ✓ I understand that I do not have to provide a reason for requesting release of my PHI.
- ✓ I understand that there may be nominal charges for copying and sending these records. This will be discussed at the time I sign or turn in this request.
- ✓ I understand that under HIPAA Privacy my access to PHI may be restricted if appropriate for my care and treatment.
- ✓ I understand that records/PHI from other healthcare entities or providers will not be released by this authorization. I will request that PHI from that entity or provider separately.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes); information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization as stated above. _____ **INITIALS**

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Print Name of Patient or Personal Representative | Description of Personal Representative's Authority/Relationship

REV. 4/06