Authorization To Use and Disclose Protected Health Information

Section A: Uses and Disclosures

Patient Name: _____ **Patient ID Number:** _____

I hereby authorize and request Center for Ambulatory Surgery, LLC, 550 Orchard Park Road, West Seneca, New York 14224 ("Covered Entity") to use and disclose my individually identifiable health information for purposes of treatment, payment and health care operations, and hereby consent to such use and disclosure, in accordance with the provisions hereof.

Description of information that may be used and disclosed:

☐ My medical records from _____ (insert date) to _____ (insert date).
☐ My entire medical record, including patient histories, office notes, test results, pathology and laboratory specimens, consultation reports, x-rays and other imaging studies, diagnoses, treatment plans, procedure results, progress notes, billing records, insurance records, and all medical records and reports sent to the Covered Entity by another health care provider.
☐ Other: _____
_____ (describe as appropriate).

The specific purpose(s) of the use or disclosure is(are) (indicate if the individual requested the use or disclosure, or the purpose was not disclosed): _____
_____

NOTE: This Authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment (other than psychotherapy notes) and confidential HIV and AIDS information only if I place my initials on the appropriate line below. By initialing one or more of these lines, I specifically authorize disclosure of the applicable health information to the person/organizations indicated above.

_____ Alcohol/Drug Information _____ Mental Health Information _____ HIV/AIDS Information

Section B: Important Information Regarding this Authorization

1. I understand that this Authorization is voluntary and that my refusal to sign this Authorization will not affect my health care, payment for my health care or my health care benefits.

2. I understand that the Covered Entity cannot guarantee that the recipient of the information will not re-disclose the information if the recipient described on this form is not required by law to protect the privacy of the information.

3. I understand that I may revoke this Authorization at any time by notifying the Covered Entity in writing, but if I do, it won't have any effect on any actions taken by the Covered Entity before they received the revocation.

4. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.

5. A copy of this Authorization may be used in lieu of the original.

Section C: Expiration

This Authorization expires on: _____ _____
(insert applicable event or date)

Section D: Signature

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my information.

Signature of patient *[or personal representative]* _____
[Authority of personal representative, i.e., parent, guardian, power of attorney, health care proxy]:

Contact Information: (*Patient's Attorney's or Personal Representative's Name, Address and Telephone Number):*

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