General Surgical Associates, PC

Release of Medical Records

Patient Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name: ________________________________ **DOB**: ________________________

By signing, I authorize ____
to use and/or disclose certain protected health information (PHI) about me to General Surgical Associates, PC.

This authorization permits ____ to use and /or disclose the following individually identifiable health information about me (specifically describe, in the space below, the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc):

____

____

____

The information will be used for the following purpose. ________ Continuation of Care ________.
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information.

The authorization will expire 1 year from the date of signature or on ______________________________.
(date)

The Practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from General Surgical Associates, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

General Surgical Associates, PC
215 East Mansion Street
Suite 3E
Marshall, Mi 49068

______________________ ______________________________________
Date Signature of patient or legal guardian

______________________________ ______________________________________
Printed name of patient or legal guardian Witness Signature

Patient/Guardian must be provided with a copy of this authorization form