PATIENT'S REQUEST: **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

THIS DISCLOSURE IS AT THE REQUEST OF THE PATIENT. THE FORM MUST BE COMPLETED AND SIGNED BEFORE INFORMATION WILL BE DISCLOSED.

I, _____ , authorize
Name of Patient

THE SURGERY CENTER OF FARMINGTON

to disclose the following protected health information:

☐ All Contents of my Medical Record
Or, Individually Check or List
- ☐ Report of Procedure
- ☐ History and Physical
- ☐ Any reports of pathology, laboratory, or radiology
- ☐ Other: Describe or list: _____

_____

The protected health information is to be used or disclosed to: ***(Insert name of person or entity who will receive the information. Provide the address of the person or entity if the information is to be mailed by the organization.)***

_____
_____
_____

This authorization shall be in force and effect until: (check one of the following)
☐ Date _____
☐ The happening of the following event: _____
☐ End of research study
☐ No expiration (can only be used if authorization is for creation of research database or research repository.)

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at the Surgery Center. I understand that a revocation is not effective to the extent that the surgery center has already relied upon this authorization. I understand that information 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 understand that I have the right to inspect or copy my protected health information to be used or disclosed as permitted under law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative If Personal Representative, Description of Authority

TO REVOKE THIS AUTHORIZATION OR TO LEARN MORE ABOUT THE SURGERY CENTER'S PRIVACY POLICIES, CONTACT:

THE SURGERY CENTER OF FARMINGTON
ATTN: PRIVACY OFFICER
400 Parkland Drive
Farmington, MO 63640
573-756-8000

After the form is completed, give a copy to the patient and place the original in the patient's record.