AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NAME_____ DOB_____

By Signing this form, I authorize _____ to Release or disclose the protected health information described below from Southern Surgical Associates, PA.

Please send this information on or about (information will not be resent without another authorization): ____/____/_____.
MO Day Year

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.): _____

____ Copies of Medical Records for the period ____/____/____ to ____/____/____

____ Copies of information described below for period ____/____/____ to ____/____/____

_____ Complete Medical Record _____ Consultations _____History & Physical

_____ Office Visit Notes _____ Treatment Plan _____HIV/AIDS

_____ Procedure Reports _____ Reports from other Physicians

_____ other (please specify) _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS; sexually transmitted diseases;
Human immunodeficiency virus (HIV) infection; behavioral health service/ psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.
The following information should not be released, even if occurring during dates above:_____
_____
_____

I have been provided a copy of Southern Surgical Associates, PA *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Carla Jennette, Privacy Officer or other appropriate office personnel.

I understand that Southern Surgical Associates, PA assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Southern Surgical Associates, PA from all legal liability that may arise from this authorization.

Patients Signature_____ Date_____

SS# _____ DOB_____

If the signature above is not that of the patient, I am acting for the patient because_____
My relationship to the patient is _____ Signed_____