Surgical Clinic Associates, P.A.
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FAMILY PRACTICE/AFTER HOURS CLINIC AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize and request The Family Practice/After Hours Clinic (covered entity) to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Patient Name: ____

Patient Date of Birth: ______________________ Patient SS#: ______________________

Patient Address: ____

Patient Phone Number: ____

***If someone other than patient named above is receiving the requested PHI, please complete below:*

Release Requested PHI to (Name): ____

Date of Birth: ____________Phone Number: ____________Fax # (if applicable):____________

Address: ____

Disclose the following PHI for treatment dates__________to__________(Please check one of the following)
( ) Progress Notes ( ) Procedure Op Notes/ Hospital Summary ( ) Lab ( ) X-ray Report
( ) Telephone Message ( ) Entire Chart ( ) Other Specified: ______________________

The above information is disclosed for the following purposes: (Please check all applicable)
( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) Other: __________

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, or HIV infection as well as information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted. I choose to have my records faxed. ___ (please initial)

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and will not apply to information already released under this authorization. Unless otherwise revoked, this authorization is effective for six months from the date signed.

Signature of Patient or Legal Representative:______________________________Date: ____________

If Legal Representative-Relationship to Patient:____

Witnessed by: ______________________________________ Date:______________________