

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security No. _____

1. AUTHORIZES: Name of Health Care Provider/Plan/Other:
Street Address:
City, State, Zip Code:
Fax Number:

2. RELEASE PROTECTED HEALTH INFORMATION TO: Name of Health Care Provider/Plan/Other: Surgery On Sunday, Inc
Street Address: 650 Newtown Pike, Second Floor
City, State, Zip Code: Lexington, KY 40508
Fax Number: 859-246-1752

I authorize the following protected health information (PHI) to be released:
[Specific description of portions of records to be released, i.e. clinic dictation, lab results, operative reports, pathology reports and *time periods of information to be released*]

This is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.

I understand that the information to be released includes (initial appropriate lines):

- Diagnoses and/or treatment
- AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment
- HIV test results
- Diagnoses and/or treatment relating to other communicable diseases

This authorization for use/disclosure is for the following purpose(s): _____

I understand that I do not have to sign this authorization and that Surgery On Sunday, Inc. may not condition treatment or payment on whether I sign this authorization. However, I understand that I have the right to revoke this authorization, in writing, at anytime, and that the revocation will be effective except to the extent that Surgery On Sunday, Inc has already taken action in reliance on my authorization. I further understand that I may inspect or copy PHI to be used or disclosed.

My written statement that I want to revoke my authorization should be delivered to:

Surgery On Sunday, Inc 650 Newtown Pike, Lexington, KY 40508

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. I also understand that information used or disclosed pursuant to this authorization may result in direct or indirect remuneration from a third party. I certify that I have received a copy of this authorization.

This authorization expires on (please list specific date or event) _____ or ninety days from today's date (whichever occurs first) and will automatically become null and void with my express revocation.

Patient Signature: _____ Date: _____