

SURGICAL ASSOCIATES

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• AFTER HOURS: 479-713-1000
1-800-364-4680 • FAX 479-521-1550

To: _____
Facility/ Physician

Address _____ City, State and Zip Code _____

I hereby request that my Private Health Information be released to:

Requesting Party _____

Address _____ City, State and Zip Code _____

Specific information to be released to the above referenced entity: _____ _____ _____
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This Authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature or within reasonable time following completion of the event which gave rise to the purpose of this Authorization.

I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

I understand that I may refuse to sign this Authorization.

Patient Name (print): _____	DOB: _____
Signature _____	Date: _____

In the event the Authorization is being executed by a personal representative, guardian, or Parent, please print your name and relationship to the patient _____

Pages sent _____ Date sent _____ Sent by _____ Faxed Mailed Picked Up