

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **SURGICAL INSTITUTE** to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name _____

Date of Birth

MM	MM	DD	DD	YY	YY	YY	YY

Social Security Number

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Patient Address _____ Phone Number (____) ____ - _____

Date(s) of Service (if known) _____

Description of information to be released: (Check all that apply)

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Admission / Registration | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records | _____ |
| <input type="checkbox"/> Nurse's Notes | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Laboratory Reports | _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Records | <input type="checkbox"/> Billing Records | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Films | | |

Description of the purpose of the use and / or disclosure: _____

The health information described herein shall be released to: (Check the appropriate category)

- Hospital Physician Insurance Company Attorney Patient Other

Name _____ (Check the appropriate delivery method)
 Mail

Address _____ Fax

City, State, ZIP _____ Pick-up Records

Phone Number _____ Fax Number _____ Other _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date / event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient's Representative _____

Relationship to Patient _____ or _____ Legal Authority (attach supporting documentation)

PATIENT IDENTIFICATION NO. _____

PATIENT _____

PHYSICIAN _____

SURGICAL INSTITUTE
3600 GASTON AVENUE, SUITE 958
DALLAS, TX 75246

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