Horizon
SURGICAL SPECIALISTS

Authorization to Release Protected Health Information

Name of Patient_____ Date of Birth _____

Address_____

City, State, Zip_____ Phone_____

_____ may release/request the following information:
Name of Entity

_____Entire Record _____Financial Records _____Office Visit Notes

_____Diagnostic Studies _____Other as listed _____

Entity or person who will receive the information:

Name _____

Address_____

City, State, Zip_____ Phone _____

Send the information electronically. Email Address: _____
For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur. ____ Initial.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer by protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date_____
Signature of Patient or Personal Representative