

**Authorization for Proliance Surgeons, Inc., P.S. to  
 Use or Disclose My Health Care Information**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:  
 \_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

**You may disclose this health care information to:**

Name (or title) and organization: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

- at my request
- other (specify): \_\_\_\_\_
- check only if practice requests the authorization for marketing purposes
- check only if practice will be paid or get something of value for providing health information for marketing purposes

**This authorization ends:** *(If disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*

on (date): \_\_\_\_\_

when the following event occurs: \_\_\_\_\_

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Proliance Surgeons, Inc., P.S. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
  - Fill out a revocation form. A form is available from the practice. Or
  - Write a letter to the practice.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
 Patient or legally authorized individual signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Time

\_\_\_\_\_  
 Printed name if signed on behalf of the patient  
 Last Update: 12/16/2005

\_\_\_\_\_  
 Relationship  
 (parent, legal guardian, personal representative)