DESERT CLIFFS SURGERY CENTER

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION

HIPPA COMPLIANT AUTHORIZATION FOR REALEASE OF INFORMATION

PATIENT NAME: _____ **DOB**: _____**SSN#**: _____

Information Requested: I consent and authorize Desert Cliffs Surgery Center to disclose all Protected Health Information ("PHI") in any form (including oral, written or electronic) to (list the Individual, facility, address, city, state, zip or self).

_____

Additionally I authorize Desert Cliffs Surgery Center to disclose the PHI via mail or facsimile. I expressly request Desert Cliffs Surgery Center disclose full and complete PHI from the time period of _____to _____ including, but not limited to, the following:

- ☐ All medical records
- ☐ All records related to _____
- ☐ All diagnostic test reports
- ☐ All billing records, including, but not limited to: all statements, invoices, itemized bills and insurance
- ☐ All records related to the amendment of any records request.
- ☐ Other _____

Method of delivery: ☐ Patient to pick up ☐ Mail ☐ Fax: _____

☐

Email_____

1. Purpose of Release

_____

_____

Authorization Effective Until:

- ☐ 1 YEAR FROM DATE OF THIS AUTHORIZATION
- ☐ DATE _____
- ☐ Other_____

I understand that this authorization may be revoked at any time, except to the extent already acted upon, by giving written notice to Requestor at the above address listed above. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization. I understand the Requestor may not re-disclose this information, and if re-disclosed, the information would no longer be protected by federal privacy rules and regulations. Any facsimile or copy of this authorization authorizes the release of the records requested herein.

Signature of Patient (if 18 years of age or older): _____Date_____

Signature of Parent or Legal Representative (if applicable): _____Date_____

Relationship to Patient, if not signed by _____Date_____

In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:

- ☐ Substance Abuse(Alcohol/Drug)
- ☐ Mental Health(Including Psychological Testing)
- ☐ HIV-Related Information (Including AIDS Testing)
- ☐ Genetic Information

THIS FORM DOES NOT AUTHORIZE THE RE-DISCLOSURE OF MEDICAL INFORMATION BEYOND THE LIMITS OF CONSENT. WHERE ALCOHOL/DRUG ABUSE INFORMATION HAS BEEN DISCLOSED THROUGH RECORDS THAT ARE PROCTED BY FEDERAL LAW, FURTHER DISCLOSER IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PATIENT OR AS OTHERWISE PERMOTTED BY SUCH LAW AND OR REGULATIONS.A GENERAL

Signature of Patient (if 18 years of age or older): _____Date_____

Signature of Parent or Legal Representative (if applicable): _____Date_____

Relationship to Patient, if not signed by Patient:_____ Date_____