Associates in Surgery, PA
Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth _____________

Associates in Surguery, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
▫ Voice Mail	▫ Message to Return Staff Members call ▫ Appointment Reminders Only ▫ All of the Above
▫ Spouse or Partner (Please list Full Name) ____	▫ Financial ▫ Medical ▫ Both
▫ All Others (Please list Full Name and Relationship) ____ ____	▫ Financial ▫ Medical ▫ Both
▫ **EMERGENCY CONTACT** ____ Please provide name and phone number.	

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 be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____Date ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

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Revised Oct 2014