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Patient Authorization to use or Disclose Protected Health Information
Acknowledgement of Notice of Privacy Practices

Section 1

I ___________________________, understand Suburban Surgical is authorized by me to use or disclose my protected health information for purpose of treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipients(s) of that information. I specifically authorize a current employee of Suburban Surgical to disclose my protected health information to individuals named in section 3 of this form. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

Section 2

Yes ☐ No ☐ Suburban Surgical may acquire and/or disclose medical records to/from any and all physicians, hospitals, and other medical institutions.

Yes ☐ No ☐ May we leave test results/messages on answering machine.

If yes, please list phone number for messages: _________________________

Section 3

Name(s) of person(s) authorized by this form that a current employee of Suburban Surgical can disclose the patient's protected health information to: example (spouse, child, parents)

Relationship to patient: ____________________________ Name: ____

Relationship to patient: _____________________________Name:_______________________________________

I fully understand and accept the terms of this authorization and I have received the Notice of Privacy Policies.

____ _____________________

Patient's/ Guardian Signature ****Appointment** Date**