



Central California Surgery

NAME _____ DOB _____

Social Security Number _____

I. My Authorization

I authorize the following using or disclosing party:

to use or disclose the following health information.

- All of my health information

- My health information relating to the following treatment or condition:

- My health information covering the period from _____ (date) to _____ (date)

- Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization Central California Surgery

Address 1552 Coffee Road, Suite 200

City Modesto State CA Zip 95355

Phone (209)248-7168 Fax (209)846-9141 Email ic@CentralCaliforniaSurgery.com

The purpose of this authorization is (check all that apply):

- At my request

- Other: _____

- To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

- To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

- On (date) 1 year from signature date

- When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:

- Patient is a minor: _____ years of age

- Patient is unable to sign because: _____

Signature of Authorized Representative. _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

- Parent - Legal Guardian - Court Order - Other: _____



III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.

- I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____

Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- I consent to have the above information released.

- I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date: _____

Time: _____