Central California Surgery

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following disclosing party

Name: _____

Address: _____

_____

Ph: _____ Fax _____

To disclose this health information to:

Central California Surgery
1552 Coffee Road, Ste 200, Modesto CA 95355
Phone (209)248-7168 Fax (209)846-9141
Email: ic@CentralCaliforniaSurgery.com

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

☐ - At my request ☐ - Other: _____

This authorization ends:

☐ - On (From date) 1 year ☐ - 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: _____