NORTH COUNTRY SURGICAL SPECIALISTS

1571 Washington Street, Suite 103
Watertown, New York 13601

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name_____

Address_____

Date of Birth _____ **Phone #** _____

[1] I authorize _____
to release protected health information from the medical records of the above named patient..

[2] This information may be disclosed to and used by:

_____(Name)

_____(Address)

[3] The type and amount of information to be used or disclosed is as follows (check off the appropriate items and include other information, where indicated)

[ ] Entire record
[ ] Problem list [ ] Medication list [ ] List of allergies
[ ] Most recent history and physical [ ] Most recent discharge summary
[ ] Laboratory results from _____(date) to_____(date)
[ ] X-ray and/or imaging reports from _____(date) to _____(date)
[ ] Consultation reports from (please supply doctors' names)_____
[ ] Other (please describe)_____

[4] This information is being used or disclosed for the following purposes:
[ ] At the request of the individual
[ ] Other_____
(I understand that once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.)

[5] Unless otherwise revoked, this authorization will expire on the following date:_____
(If I fail to specify an expiration date, this authorization will expire six months from the date of signing**.)**
I, the undersigned have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn be me by notifying my provider in writing at any time except to the extent that action has been taken in reliance upon it. The provider is released and discharged of any liability and the undersigned will hold the provider harmless, for complying with this 'Authorization for Release of Medical Information'.

_____ _____
Signature of Patient or Parent or Legal Representative **Date**

_____ _____
Name of Parent or Legal Representative (Please Print) **Relationship/Authority**