Surgical Associates, s.c.
General and Vascular Surgery

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip, _____ Phone

I, THE UNDERSIGNED, HEREBY AUTHORIZE:

Surgical Associates, S.C.
2400 Pine Ridge Blvd.
Wausau, WI 54401

TO DISCLOSE PROTECTED HEALTH INFORMATION TO:

_____
Individual/Entity receiving information

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE USED and/or DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed: [check all that apply]

☐ The entire medical record, ***excluding*** records pertaining to mental health treatment, developmental disabilities, alcoholism and/or drug abuse treatment, HIV/acquired immune deficiency syndrome (AIDS) records or genetic information.

☐ Operative and Lab Reports ☐ X-ray reports ☐ Office/Clinic Notes Only ☐ Other:_____

I hereby give special permission to release information and/or records pertaining to: [check all that apply]

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol/Drug Abuse ☐ HIV/AIDS ☐ Genetic Information

PURPOSE FOR DISCLOSURE: [Check all that apply]

☐ Medical Care ☐ Personal Use ☐ Legal Investigation ☐ Insurance Eligibility/Benefits ☐ Claims Resolution
☐ Research ☐ Other:_____

PATIENT'S RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of this Authorization - I understand that if I sign this Authorization, I will be provided with a copy of it.

Right to Refuse to Sign this Authorization - I understand that I am under no obligation to sign this form

Right to Withdraw this Authorization - I understand that I have the right to withdraw this Authorization at any time by providing a written statement of withdrawal. I am aware that my withdrawal will not be effective regarding the uses and/or disclosures of my health information that has been made prior to receipt of my withdrawal statement.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this Authorization may be subject to re-disclosure and in such case, it would no longer protected by federal or state privacy and security standards.

EXPIRATION DATE: This Authorization will remain in effect until [indicate date or event] _____. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature:_____ **Date:**_____
(If signed by other than individual, state relationship)

Print Name:_____