Center of Surgical Specialist Advanced Knowledge. Expert Car	s, P.C.	e or Disclose My Health]	Information
Patient name:	Previo	ous name:	
Date of birth:	Social Security Numb	oer:	
I. <u>My Authorization</u>			
You may use or disclose th	e following health care information (cl	heck all that apply):	
(Circle include or of Include or Exclude: Include or Exclude: Include or Exclude: Include or Exclude:	a maintained by the above named practice exclude for each of the following) My health information related to drug a My health information related to alcohe My health information related to HIV/A My health information related to psych psychotherapy notes ating to the following treatment or conditional mathematical statement of the stat	abuse ol abuse AIDS ological or psychiatric cond	
	r the date(s):		
You may disclose this heal			
Name (or title) and organiza	tion		
	City		Zip
Reason(s) for this authoriz	ation (check all that apply):		
At my request,Other (specify)			
	□ on (date) t occurs		
II. My Rights			
enrollment). However, I doTo take part in a result of the par	o sign this authorization in order to get he have to sign an authorization form: esearch study. or care when the purpose is to create health		
I may revoke this authorizat	ion by submitting a written letter to the oractice based upon this authorization. In nce.		

Patient or legally authorized individual signature	Date	Time

Printed Name if	f signed on	behalf of the	patient
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Relationship (parent, legal guardian, personal representative, etc.)