



Center of Surgical Specialists, P.C.  
Advanced Knowledge. Expert Care.

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**Authorization to Use or Disclose My Health Information**

Patient Name: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

All my health information maintained by the above named practice

**(Circle include or exclude for each of the following)**

Include or Exclude: My health information related to drug abuse

Include or Exclude: My health information related to alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

My health information relating to the following treatment or condition: \_\_\_\_\_

My health information for the date(s): \_\_\_\_\_

Other: \_\_\_\_\_

**You may disclose this health information to:**

Name (or title) and organization \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

At my request,

Other (specify) \_\_\_\_\_

**This authorization ends:**  on (date) \_\_\_\_\_

when the following event occurs \_\_\_\_\_

**II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study. or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization by submitting a written letter to the office. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature Date Time

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