JERNIGAN SURGERY CLINIC, PLLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Birthdate: _____Last 4 of SSN: _____
Address: _____

I authorize Jernigan Surgery Clinic, PLLC or the following person or organization (specify if applicable _____ to:
□ disclose my health information to: _____
(Name and Address) – Specify Hospital, Doctor, etc.

□ obtain/request copies of my health information from: _____
(Name and Address) – Specify Hospital, Doctor, etc.

Purpose of use, disclosure, and or request:
□ Continuation of care/treatment □ Attorney □ At the request of the patient
□ Payment □ Other, specify: _____

I authorize use and/or disclosure of information covering treatment from: _____ to: _____
(enter specific dates)

Information to be used and/or disclosed:
□ Abstract (Example: History and Physical, Discharge Summary, Operative Report, and Pathology Report, if applicable)
□ Itemized Bill □ Radiology Film □ Emergency Department Record
□Other (Specify): _____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or AIDS virus.

This authorization will expire 90 days from the date of your signature unless you specify a different expiration date, event, or condition.

Please specify: _____

I understand I have a right to revoke this authorization at any time except in the event that release of information has already occurred in agreement with my prior authorization.

I understand that in order to revoke an authorization a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Office Manager of Jernigan Surgery Clinic, PLLC. The revocation document is to is to bear the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, this authorization is for release of records in a third party for payment, enforcement of eligibility of benefits purposes, such as worker's compensation, health insurance, application for insurance, etc. my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may affect payment for services I receive and I may become responsible for all charges incurred. I understand it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carriers with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

_____ _____
Date **Patient (or patient representative)**

_____ _____
Witness **Relationship and/or authority to act for the patient**