AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR PURPOSES REQUESTED BY PHYSICIAN'S OFFICE

I, _____, hereby authorize University Surgical Associates, PC to:

_____ use the following protected health information, and/or

_____ disclose the following protected health information to: _____

_____

Specific description of information to be used or disclosed (including date(s))

_____

_____

_____

This protected health information is being used or disclosed for the following **purposes**:

_____

_____

_____

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization at any time by notifying the providing organization in writing. I understand that a revocation is not effective to the extent that University Surgical Associates, PC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

University Surgical Associates, PC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to University Surgical Associates, PC from a third party (if applicable).

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____ _____

Witness Signature Date