CAHABA VALLEY SURGICAL GROUP, PC

Rex A. Sherer, MD Timothy L. Christopher, MD William C. Braswell, MD

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: **Date of Birth:**

Patient Address: **SSN:**

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

2. What information is to be disclosed? Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure: Check all appropriate:

☐ Entire record ☐ Op notes ☐ Billing records Specific other

Information that *may not be used or disclosed:*

☐ *No restrictions* *Or specify here:* _____

3. Who may request disclosure? The name or other specific identification of the person(s), or class of persons, *authorized to make the requested use or disclosure: (Check all that apply)*

☐ Myself only ☐ Immediate blood/legal family members ☐ Emergency contacts I have indicated

☐ Other *Specify* _____

4. Who is to receive the requested information? The name or other specific identification of the person(s), or class of persons, to whom the Practice *may make the requested use or disclosure: Enter name, phone number, fax and other information about recipient:*

Recipient: _____

5. Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

Check one:
☐ 12 months from the date of this Authorization
☐ The duration of my current episode of care from this provider
☐ Other, specify _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization. (Please print and sign and date in ink).

6. _____ _____

Patient Signature or Personal Representative Date

(If submitted online, name entered is valid as written authorization).