Associated Surgeons & Physicians

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: _____ **Social Security #: last 4 digits** ____-____-____-____ **Date of Birth:**_____

Street: _____ **City/State:** _____ **Zip:** _____

Purpose of request (who will be authorized to receive information) - I authorize the practice to disclose or provide protected health information, about me, to: (please identify entity, person or persons who will receive the information):

Entity Providing Information:

Practice: Center for Colon & Rectal Care

Provider: _____

Address: 7988 West Jefferson Blvd.

City/State/ Zip: Fort Wayne/IN/46804

Phone: (260) 436-0259

Fax: (260) 436-0784

Entity Receiving Information:

Name: _____

_____

Address: _____

City, State, Zip:_____

Phone: _____

Fax: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above: (please provide a written description of the information to be disclosed):

- ☐ Entire patient record, including but not limited to: office notes; lab results; x-rays; hospital, nursing home, home health, hospice, and other physician records; record of HIV and communicable disease testing; record of mental health or substance abuse treatment; and financial history report (previous 3 years only).
- ☐ Office notes, labs and x-rays only.
- ☐ Only send the following: _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

- ☐ Patient transferring to our care.
- ☐ Patient referred to us for treatment of: _____.
- ☐ Other (please specify): _____.
- ☐ Patient Request

Expirations or termination of authorization: This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year):_____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

patient signature date

Copies of signed authorizations are available upon request.