Central Surgical Associates, PLLC Authorization for Release, Use and Disclosure of Health Information

Name: _____ Date of Birth: _____

Other names used: _____

Address: _____ City, State and Zip: _____

Home Phone: _____ Work or Cell Phone: _____

Please select one of the following:

☐ **I authorize Central Surgical Associates to disclose my health information to the following:**

_____

☐ **I authorize the following entities to disclose my health information to Central Surgical Associates:**

_____

Purpose of Request: _____ (be specific)

I authorize the following information to be disclosed: (Please circle all that apply)

- Complete Medical Records
- Discharge Summary
- Operative and Procedure reports
- Consultation reports
- Laboratory Results
- X-ray and Imaging Results
- Pathology Results
- Clinical and Progress Notes
- Billing Records
- Other-Please list specific items: _____

Please select one of the following:

☐ I will pick up copies of my records

☐ Fax my records to: _____

☐ Mail copies of my records to the following: _____

- I understand that the information in my health records may include information pertaining to sexual transmitted disease, AIDS or HIV.
- I understand this release will expire exactly one year from today.
- I understand that I have the right to revoke this authorization in writing by mailing my revocation to the address at the bottom of this form.
- I understand that unless the purpose of this authorization is to determined payment of a claim or benefits, Central Surgical Associates may not condition the provision of treatment or payment for my care on my signing this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that mental health or psychotherapy records require a separate release form.
- I understand my treatment records may also include information about behavioral or mental health treatment, and/or alcohol and substance abuse. This category of medical information/records is protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I understand there will be no charge for records to be sent to my Primary Care Physicians office.
- I understand there will be no charge for a personal copy of my health information to be release to me by fax, email or pick up.
- I understand there WILL be a charge for my health information due to records needed for ligation.

_____

Signature of patient, parent, or legal authorized representative

_____

Relationship to patient

_____

Date

Central Surgical Associates, PLLC
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Jackson, MS 39202
P: 601-944-1781
F: 601-353-0439