CENTRAL SURGICAL
ASSOCIATES, PLLC

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

I. THE PATIENT.

Patient's Name:__________________________ Date of Birth: ________________

Social Security Number:____________________

II. AUTHORIZATION. I authorize Central Surgical Associates, PLLC to use or disclose the following: (check one)

☐ All of my medical-related information

☐ My medical information ONLY related to:

☐ My medical-related information from ________________, 20__ to ________________, 20__.

☐ Other:____.

Hereinafter knowns as the "Medical Records".

III. DISCLOSURE. Central Surgical Associates, PLLC has my authorization to disclose Medical Records to: (check one)

☐ Any party that is approved by Central Surgical Associates, PLLC.

☐ ONLY the following party:

Name:____________________________________ Address:________________________________

Phone:____________________________________ Fax:____________________________________

E-mail:____________________________________

IV. PURPOSE. The reason for this authorization is: (check one)

☐ Personal ☐ Legal/Attorney ☐ Insurance ☐ Disability ☐ Continuing Care ☐ School ☐ Worker's Compensation

☐ Other (be specific):____

V. TERMINATION. This authorization will terminate: (check one)

☐ Upon sending a written revocation to Central Surgical Associates, PLLC.

☐Other:____

VI. SENSITIVE INFORMATION RELEASE

I understand that this health information may include sensitive information. By signing this form, I specifically authorize the release of each initialed sensitive information item:

__Substance Abuse Treatment Information __Mental Health Information __Genetic Testing

__HIV related information (including AIDS related testing) __Other Abuse

VII. ACKNOWLEDGEMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. If you wish to take your permission away, please send a written notice with signature to Central Surgical Associates, PLLC 1190 North State Street, Suite 502, Jackson, MS 39202. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the Federal privacy regulations. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I understand that I am entitled to receive a copy of this form after I sign it. A copy of this authorization is as valid as the original.

VIII. SIGNATURE.

I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". I acknowledge this authorization with my signature below.

Signature of Patient/Representative: ________________________________ Date:________________

Print Name: _________________________________ Relationship to Patient:______________________

If the patient listed above is under the age of 18, this authorization form and any revocation must be signed by a parent, guardian, or other person who has the authority to act on the behalf of minor. As the person signing for the patient, I, the parent, guardian, or legal representative warrant that I have the legal authority to act on behalf of the patient and that I am not prohibited by Court order or law from having access to the requested medical records.