GSA
GENERAL SURGERY
ASSOCIATES

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth:_____

Address: _____ Telephone: _____

_____

I authorize General Surgery Associates, LLC to disclose my Protected Health Care information to:

Person or entity receiving information: _____

Information to be disclosed:

_____Complete copy of medical record

_____Only dates of care between _____to_____

_____to_____

The information authorized for disclosure may related to (check of applicable)
_____Acquired immunodeficiency syndrome (AIDS)
_____Human immunodeficiency virus (HIV) infection
_____Alcohol or drug treatment
_____Mental illness (excluding psychotherapy notes)

Additional comments: _____

_____

I understand that information used or disclosed based on this authorization may not be protected from further disclosure by the recipient of this information.

_____ _____
Date Signature of patient or representative

_____ _____
Expiration of authorization Representative's relationship to patient