SURGERY Center OF LANCASTER

810 Plaza Blvd, Suite 101
Lancaster, PA 17601
Phone: 717-431-2368
Fax: 717-431-2540

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Patient Name: _____ Social Security Number:_____

Person(s) authorized to make the use or disclosure of the information:
_____

Person(s) authorized to receive the information:
_____

Specific description of information (including date(s)):
_____

1. Surgery Center of Lancaster must complete the following:

   a. What is the purpose of the use or disclosure? (If the patient does not wish to state the purpose, indicate "at the patient's request"): _____

   b. Will the surgery center receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_____

2. The patient or the patient's representative must read and initial the following statements:

   a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. Initials:_____

   b. I understand that I may see and copy the information described on this form if I ask for it, and that the surgery center will give me a copy of this form after I sign it. Initials:_____

   c. I understand that this authorization will expire on ____/____/_____. Initials:_____

   d. I understand that I may revoke this authorization at any time by notifying the surgery center in writing, but if I do revoke it, the revocation will not have any effect on any actions the surgery center took before it received the revocation. Initials:_____

_____ _____
Signature of patient or patient's representative *Date*

Printed name of patient's representative: _____

Relationship to patient: _____