

PHI Use and Disclosure Authorization

Surgical Anesthesia Services, LLP

I authorize _____ to use and disclose of the following protected health information.

Purpose of the Disclosure: _____

Will this information be used for marketing? Yes____ No____

Has this information been previously de-identified? Yes____ No____

Name of Entity or Person(s) to Receive Information:

This authorization is effective through (check one):

____/____/____ or

NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to **(address or email)**. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

Name of patient or Personal Representative (Type/Print)

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority