TWO
RIVERS
SURGERY
CENTER LLC

DISCLOSURE AUTHORIZATION FORM

FOR HEALTHCARE PROVIDER TO DISCLOSE HEALTH INFORMATION TO THIRD PARTIES

I hereby authorize my Provider to use and release my Health Information, as designated below, **to:**

Recipient :(who may information may be released to):

_____

Recipient Address: _____

Recipient Telephone Number: _____

Recipient Fax Number: _____

The following Health Information about me may be used/disclosed (*check each either "Yes" or "No/NA"*):

	Yes	No
My entire medical or billing record	☐	☐

Except the following information:

_____

_____

_____

The Health Information checked **"Yes"** above may be used for the following Purpose(s):

☐ At my request; or

☐ For the Purpose of:

_____

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and it's implementing regulations ("HIPAA"), as may be amended from time to time. I understand that I have the right to revoke this Authorization, at any time prior to my healthcare provider's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in my provider's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to my provider's Privacy Officer.

I understand that I am not required to sign this Authorization and that my healthcare provider may not condition treatment on my signing of this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This Authorization expires automatically upon my provider releasing my Health Information as needed to fully accomplish the above-described Purpose(s). I hereby acknowledge receipt of a copy of this Authorization.

_____	_____	_____
Date	Signature of Individual (or Legal Representative)	Representative's Authority