AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

(General Form for Use by Providers, Not Health Plans)

By signing this Authorization, you are permitting the use and/or disclosure of your health information for the limited purpose(s), and in the limited manner, described in this form. Except as authorized by this form, we are required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices.

Refusals of Service

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this Authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this Authorization permitting us to disclose the results to your employer.

Otherwise, your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit does not depend on your signing this form. **You may refuse to sign this form**
(Note to Employees Presenting This Form: If the treatment of the patient, payment for the patient's care, or enrollment of the patient in a health plan is conditioned on the patient signing this form, no use or disclosure other than that upon which treatment, payment, or enrollment has been conditioned can be authorized on this form. A separate authorization would be needed for any other use or disclosure.)

Consequences of Signing this Form

Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or Organization to whom your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others.

Revocation

You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization to the extent that it pertains to the insurer’s right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to the Bristol Surgery Center.

FACILITY	DESIGNATED CONTACT
Bristol Surgery Center	Lola McVey, Privacy Officer 350 Blountville Highway, Suite 108 Bristol, TN 37620 423.844.6120

Expiration

Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new Authorization form.

PATIENT AUTHORIZATION

I hereby authorize employees, Medical Staff Members or other agents of

____

Name of Organization

to use or disclose the following protected health information

____	Copy of the Complete Record(s)	____	Lab Report(s)
____	History/Physical Examination	____	Progress Notes
____	Discharge Summary	____	Radiology Reports/Film(s)
____	Operative Report	____	Pathology Report(s)
____	Emergency Dept. Record(s)	____	Other as specified below:

____

____

(If this form authorizes the use or disclosure of psychotherapy notes, it may not be used to authorize the use or disclosure of any other Protected Health Information. A separate authorization is needed for any other use or disclosure.)

To be released about me from the health record of:

Patient Name: ____________________________ Date of Birth_____________

Social Security Number:_______________ Date(s) of Treatment_____________

for the following purposes:

___ At the request or direction of the undersigned individual

___ Other (describe): ____

____

This authorization also includes any information in my medical records regarding diagnosis/treatment of alcohol/drug abuse, psychiatric or mental illness, immunodeficiency syndrome (AIDS) or tests for human immunodeficiency virus (HIV)

The health information described above may be used by or released to:

____

____

This Authorization expires:

___ On the following date: _ _ / _ _ / _ _

___ When the following event occurs:

____

___ No expiration (permitted only for Authorizations used to create or maintain research databases or repositories)

I understand this authorization is subject to revocation by me at any time by giving written notice, and unless otherwise specified will expire six (6) months from the date signed by patient or legal authorized agent and covers only treatment prior to that date.

____
(Patient's Signature*)

____________________________________ ____________________________
(Witness) (Date)

*The above individual is unable to consent because (check one):

___ Minor

___ Incapacity

___ Incompetent

___ Other (explain):

____

I therefore consent on behalf of the individual named above.

____________________________________ ____________________________________
(Signature) (Relationship)

____________________________________ ____________________________
(Witness) (Date)