Surgery Group S.C.

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION:

Please read this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name_____ Date of Birth_____

Street Address_____

City, State, and Zip Code_____

Phone Number_____

Medical Record Number_____

I hereby authorize that a copy of my personal protected health information be provided to me by Surgery Group, S.C. for my records.

Disclosure will include (check all that apply)

___Consultation Report ___History & Physical

___Laboratory Report ___Progress/Physician Notes

___Operative Report ___Radiology Report

___Pathology Report ___Other_____

Records for the period (dates) from_____ to _____

Patient Signature_____Date_____

Staff Signature_____Date_____