GWINNETT SURGICAL ASSOCIATES

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Gwinnett Surgical Associates to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Gwinnett Surgical Associates to use or disclose to _____ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). _____

_____

_____

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Gwinnett Surgical Associates has acted in reliance upon this authorization. My written revocation must be submitted to Gwinnett Surgical Associates' Privacy Officer at 631 Professional Drive, Suite 300, Lawrenceville, GA 30046.

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Patient's Name Date

_____

Printed Name of Patient or Legal Guardian