Pend Oreille
surgery center, llc.

Authorization for disclosure of health care information

– PLEASE FILL OUT COMPLETELY –

I AUTHORIZE PEND OREILLE SURGERY CENTER, LLC TO USE OR DISCLOSE HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name. _____

Date of Birth. _____ Patient Social Security Number. _____

Person(s) or Organization(s) authorized to receive the information:

Specific description of the information that may be used or disclosed (including date(s)):

Specific description of how the information may be used:

_____

1. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Pend Oreille Surgery Center, LLC in writing.
2. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
3. I may **inspect or copy** any information used or disclosed under this agreement.
4. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

IMPORTANT NOTE:

You have the right to specify what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03 or, if your entire medical record is included, "all health information."

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to specify who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).