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Phone (256) 492-0020
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SurgicalAssociatesGadsden.com

Surgical Associates of Gadsden

HIPAA-Health Insurance Portability & Accountability Act

Date: _____

1. I hereby authorize **Surgical Associates of Gadsden, P.C.** Its agents, employees & contractors, to release & discuss all or any part of my medical records, medical condition, & treatment with the following: (List names of friends or family we need to be able to discuss your medical information with)

_____	_____	_____
Name	Home #	Cell #
_____	_____	_____
Name	Home #	Cell #

2. I hereby authorize the release & disclosure of any & all of my medical records to any other individual or entity, including, but not limited to, any referring physician, hospital, or other health care provider, which in the opinion of the staff or the physicians of **Surgical Associates of Gadsden. P.C.** may be of assistance in providing for continuing my medical care & treatment or for assisting in any reimbursement or benefits.

3. I hereby authorize & request that **Surgical Associates of Gadsden. P.C.** has my permission to release my medical records by fax or mail to my medical physician, other healthcare provider, hospital, attorney, employer, workman's compensation, disability or insurance company.

4. I hereby authorize & request that **Surgical Associates of Gadsden. P.C.** has my permission to contact me with my person medical information by my home phone, work number, cell number, or by voice mail. I also authorize the automated Phone Tree system to contact me via phone or email to remind me of my appointments.

5. This authorization shall expire on _____, or at the latest, 2 years from the date indicated above. I understand I may revoke this authorization at any time, in writing, unless **Surgical Associates of Gadsden. P.C.** has relied on this authorization.

6. I understand that the information disclosed pursuant to this release may be disclosed by the authorized recipient & no longer protected by the privacy rules of the Health Insurance Portability & Accountability Act of 1996.

7. I acknowledge that (I/patient) (have/has) been provided access to "HIPAA- Health Insurance Portability & Accountability Act" of **Surgical Associates of Gadsden. P.C.**

_____	_____
Signature of Patient, Personal Representative or Legal Guardian	**Date**
_____	_____
Staff member Witness	**Date**