Allied Physicians Surgery Center

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I hereby voluntarily authorize the disclosure of information from my protected health record.

Patient name (Printed):____ Date of Birth____________________

II.

The Information is to be disclosed by:	The information is to be provided to:
NAME OF FACILITY: Allied Physicians Surgery Center	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS 53990 Carmichael Dr; Suite 100	ADDRESS
CITY/STATE/ZIP South Bend, IN 46635	CITY/STATE/ZIP

III. The purpose or need for this disclosure is (check all that apply):

	Further Medical Care		Attorney		School		Research
	Personal Use		Insurance		Disability		Other (specify below)

____

IV. I understand there will be a minimal fee associated with this request (45 CFR § 164.524) and wish to receive my records as indicated (cash, check or money order accepted):

	Printed Paper Copy	Fee is $1.00/page for the first 10 pages; $.50/page for 11-50; and $.25/page for pages 51+	
	Secure Email	Fee is $5.65	Email Address:
	Flash Drive (Qty 1)	Fee is $9.90. Additional $5.65 will be charged per additional flash drive	
	CD-R (Qty 1)	Fee is $6.65 per CD. Additional $6.65 will be charged if more than one CD is needed.	
	Mail Request*	Postage fee will be accessed	
	Pick up Records	Phone number to call when records are ready:	

**Records will be mailed to address provided at top of form*

An additional fee of $10.00 will be assessed for requests that need processed within 2 business days
An additional fee of $20.00 will be assessed if records need to be certified prior to sending

V. The information to be disclosed from my health record: *(check appropriate box(es))*

	Only records related to	
	Only records for date(s)	
	Other (please specify)	
	Entire medical record	

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

	Alcohol/Drug Abuse Treatment		HIV/AIDs related treatment		Sexually Transmitted Diseases
	Mental Health (other than Psychotherapy notes)		Psychotherapy Notes ONLY*		

**By checking this box, I am waiving any psychotherapist-patient privilege*

VI. I understand that if I do not specify an expiration date, event or condition above, this Authorization will expire in sixty (60) days (or in the case of PHI concerning mental health services, one hundred and eighty (180) days) from the date this Authorization is signed by the above-listed patient.

I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Surgery Center. I understand that I have a right to revoke this Authorization at any time, in a letter addressed to the Surgery Center at the above- listed Surgery Center address, but the revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Surgery Center expressly for disclosure to the above-listed Person/Entity.

I understand that treatment and payment cannot be conditioned on whether or not I sign the authorization unless health care services are provided for the sole purpose of providing information to a third party (i.e. fitness for duty, life insurance physical, etc.) or research-related treatment to which I have agreed to, in which case, the services may not be provided unless I sign the authorization.

I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact Allied Physicians Surgery Center's Medical Records Department at (574) 807-8654.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE

Completed form can be faxed to (574) 247-3350; or

Mailed to:

Allied Physicians Surgery Center
53990 Carmichael Dr.; Suite 100
South Bend, IN 46635

Internal Use Only:

Medical Record Fee	
Method of Payment/Date Received	
Date Request Complete	
Date records were mailed or patient contacted	
Request completed by	