CVT Surgical Center

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INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Date _______________________________ Patient MRN ____________________________

Patient Name __________________________________ Date of Birth _________________

Address ____

Telephone _____________________________ Last Four of SSN ______________________

__ I hereby authorize ____ to release all information contained in my medical records file to CVT Surgical Center.

__ I hereby authorize CVT Surgical Center to release all information contained in my medical records to the physician, clinic, or individual named below.

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Information to be Released

____ Complete Medical Record

____ Partial Medical Record specifically to include:

History and Physical Exam	X-Ray Reports	Itemized Bill
Laboratory Test Results	X-Ray Films	Other (Specify)
Photographs	Discharge Summary	
Diagnosis & Treatment Codes	Progress Notes	
Consultation Reports	Complete Billing Record	

Purpose of the Requested Disclosure of Protected Health Information – I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be “at the request of the individual”) ____

Signature of Patient or Representative Who May Request Disclosure – I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party, I understand that services may be denied if I do not authorize the release of information related to such health care services to third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge _________________________, its employees, agents and owners of any liability and the undersigned will hold them harmless for complying with this authorization.

____ ____

Signature of Patient or Personal Representative **Printed Name of Patient or Personal Representative**

____ ____

Date **Description of Personal Representative’s Authority**