AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:____

Date of Birth: ____________________________ ID Number: ____________________________

Organization providing the information

Organization receiving the information

Specific description of the information (including date(s) of healthcare) to be disclosed:

This authorization shall be in force and effect until: (check one of the following)

- ❑ Date ________________________
- ❑ The happening of the following event:
- ❑ End of research study at which time this authorization to use or disclose this protected health information expires.
- ❑ No expiration (can only be used if authorization is for creation of research database or research repository.)

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Indio Surgery Center, Inc
46-900 Monroe St, Ste B-201
Indio, CA 92201
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that the Indio Surgery Center, Inc has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Check One of the Following:

- ❑ I understand that the Indio Surgery Center, Inc will not condition my treatment on whether I provide authorization for the requested use or disclosure.

- ❑ I understand that the health care provided by the Indio Surgery Center, Inc is solely for the purposes of creating protected health information for______________________(***insert third party name)*** and that my authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the Indio Surgery Center, Inc will not provide health care services to me.

- ❑ I understand that the treatment being provided by the Indio Surgery Center, Inc is related to research and that my authorization of disclosures for research related purposes is a condition of this treatment. I understand that if I do not sign this authorization, then the Indio Surgery Center, Inc will not provide research related treatment to me.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

- Refuse to sign this authorization.

____ ________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority