METROPOLITAN SURGICAL CENTER

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Patient's Consent to Disclose Protected Health Information to Authorized Persons

Patient's Legal Name _____ **Date of Birth** _____

Previous Name _____ **Phone Number** _____

1. **Authorization to Disclose PHI (Protected Health Information).** I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. **Persons to Whom Disclosure May be Made.** Provider may disclose my PHI to the following persons:

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. **Purpose of Disclosure**. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health, per my request.

4. **Expiration of Authorization.** This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. **Conditioning of Treatment**. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. **Re-disclosure by Recipient.** I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law.

7. **Acknowledgment of Reading and Agreement.** I have read and understand this authorization.

_____ _____
Patient Signature or Representative Date

_____
Printed Name

If a Representative Signs, state the Representative's Authority: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED