MINNETONKA AMBULATORY SURGERY CENTER
AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, MSC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

I, _____, hereby authorize the use of the following health information:

TO: (Print/Type Name & Address)

_____
_____
_____
_____

PATIENT: (Print/Type Name & Address)

_____
_____
_____
Date of Birth: _____

___H&P	___O.R. Anes. Notes	___EKG
___PACU Nurse's Notes	___Lab Reports	___Pathology Reports
___Doctor's Progress Notes	___X-Ray Reports	___O.R. Dictation
___Discharge Summary	___Discharge Instructions	___Other _____

(If you are requesting the disclosure of information to yourself, you may write "any and all information" or "full medical chart." Such broad request will not be honored if the requested disclosure is to a third party.)

I understand the above requested information may contain sensitive medical information, such as information regarding HIV/AIDS status, venereal disease, tuberculosis and other infectious diseases, pregnancy status, mental illness, addiction, and other sensitive information.

( ) I agree to the disclosure of above specified records without any modifications
( ) Please censor the above requested disclosure as follows: _____
_____

Intended Purpose:

_____
_____

(If you are requesting the disclosure of information to yourself, you may leave this section blank or write "at the request of the individual." If the requested disclosure is to a third party, you must state the purpose.)

Important Notices:
I understand that once the requested information has been released pursuant to this authorization, we cannot guarantee the continued privacy of the information. The recipient may not be subject to federal and state laws that protect the privacy of health information and might re-disclose the information to additional parties.

I understand that I can revoke this authorization at any time by signing the revocation section of this form and returning it to our facility. We will honor such revocation as soon as we receive it except to the extent we, or other persons allowed to act under the authorization, have already acted in reliance on this authorization.

This authorization will expire once the information requested has been released and received by the designated individual or third party.

I understand that there is no obligation to sign this authorization. In addition, I understand that the ability to obtain treatment, payment, and eligibility for benefits does not depend on whether this authorization is signed except if we are providing health care solely for the purpose of disclosure to a third party.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____
Date Signature of Patient or Personal Representative

_____
Relationship to Patient

For Office Use Only:

☐ *Copy provided to Patient/Personal Representative*

REVOCATION SECTION

I hereby revoke this authorization

_____ _____
Signature Date