

**PLEASE FILL OUT COMPLETELY**  
**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

I AUTHORIZE THE SURGERY CENTER OF SILVERDALE, LLC, TO USE OR DISCLOSE HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_

Person(s) or Organization(s) authorized to receive the information:

Specific description of the information that may be used or disclosed (including date(s)):

Specific description of how the information may be used:

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- 1) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the Surgery Center of Silverdale, LLC, in writing.
  - 2) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
  - 3) I may **inspect or copy** any information used or disclosed under this agreement.
  - 4) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

\_\_\_\_\_  
Patient's Signature or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

**IMPORTANT NOTE:**

You have the right to specify what information you are authorizing for release (*e.g.*, "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (*e.g.*, the names of your health care provider(s)).

You have the right to specify who is going to use it and what it is going to be used for. (*e.g.*, John Smith, PhD / Research).