SURGICAL ASSOCIATES MANSFIELD

Methodist MEDICAL GROUP

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: ___ Social Security Number: _____

Account Number: _____Date of Last Visit: _____

Physician Seen: _____

1. I authorize the use or disclosure of the Patient's health information, as described below.

2. The following individual(s) or organizations are authorized to make the disclosure:

   Name: _____

   Address: _____

   Phone: _____ Fax: _____

3. The type and amount of information to be used or disclosed is as follows: (Please Check)
   ___ Entire Health Record ___ Operative Procedures ___ Pathology Report ___ Echocardiogram
   ___ History & Physical ___ X-ray/Imaging Reports ___ X-ray Film ___ Laboratory Reports
   ___ Other (please describe) _____

4. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and/or drug abuse.

5. This information may be disclosed to and used by the following individual(s) or organization(s) (*please include the name and address of the individual or organization*):
   _____

6. This information is being disclosed for the following purpose(s); _____

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to MedHealth, 3400 W. Wheatland Rd, Suite 453, Dallas, TX 75237. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
   _____

   This authorization will expire 12 months from the date of signing.

9. I understand that my treatment, payment, or eligibility to file to insurance company will not be conditional on the completion and signature of this form.

10. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

11. I understand that I will be given a copy of this authorization form after signing.

_____ _____
Signature of Patient/Responsible Party or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relation to Patient Date

_____ _____
Signature of Witness Date