Authorization for Use or Disclosure of Information

University Surgical Associates

Exceptional surgeons. Compassionate care.

University Surgical Associates, 979 E. Third St., Suite C-300, Chattanooga, TN 37403 - (423) 267-0466 - Fax (423) 757-0748

Patient's Name (First, Middle, Last) _____ Account # _____

Street Address _____ SS # _____

City _____ State _____ Zip _____ Date of Birth _____ Home Phone _____

Release of Information **FROM** University Surgical Associates

☐ I authorize University Surgical Associates to release copies of my records as listed below. The information should be sent to:

Physician Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by University Surgical Associates.

Release of Information **TO** University Surgical Associates

☐ I authorize the release of information from:

Physician/Institution _____

Address _____

City _____ State _____ Zip _____

Please send information requested below to:

Dr. _____ Dept./Clinic _____

Phone Number _____ Fax Number _____

Dates of Treatment

_____

The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

Information to be Disclosed

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-Rays
- ☐ Clinic Visits
- ☐ ER Records
- ☐ EKG
- ☐ Lab
- ☐ Physician Orders
- ☐ MD Office Treatment Records
- ☐ Other

_____

Purpose of Disclosure

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of Care
- ☐ Worker's Comp
- ☐ Other (Specify Below)
- ☐ Diability
- ☐ Insurance
- ☐ Deposition
- ☐ Billing
- ☐ Per Patient Request

_____

Expiration date for expressed authorization is _____ . If the patient does not express a desire for a specific date or condition to revoke their authorization, this authorization will expire ninety days from the date signed by the patient or legal authorized agent. I have read, or have had read to me, the above statements and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist, as detailed by federal law, such as **(1)** University Surgical Associates has taken action in reliance thereon, or **(2)** The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.
In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the Privacy Officer of University Surgical Associates. This revocation document must contain the signature of the patient or patient's legal representative, and that signature must be formally certified by a Notary Public. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Signature of Patient/Appropriate Legal Representative _____ Date _____

Relationship if NOT Patient _____ Date _____

Witness _____ Date _____