Minimally Invasive Surgical Specialists

Authorization for Release of Protected Health Information

: 727.274.1330
: 855.274.0039

Patient Name: _____

Date: _____

I authorize Minimally Invasive Surgical Specialists, LLC, to use or disclose my health information as described below.

1. **Type of information**: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

☐The entire health record (all information)	
☐Activity documentation	☐Minimum Data Set
☐Admission/re-admission documentation	☐Medication and treatment records
☐Advance directives	☐Nursing documentation/progress notes
☐Assessments, flow-sheets	☐Progress notes
☐Care plan	☐Reports from lab, x-ray, and other diagnostic ☐tests
☐Informed consent	☐Face sheet
☐History, exams and other records	
☐Other: (Describe as specifically as possible)	

2. **Recipient of information**: The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Primary Care Physician		Specialist Physicians	
Name:		Name:	
		Name:	
Phone Number		Phone Number	
		Phone Number	

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3. **Purpose of use/disclosure**: This information described on the previous page will be used for the following purpose(s):
    a. ☐Initiated at the request of the patient
    b. ☐My personal records
    c. ☐Sharing with other healthcare providers as needed
    d. ☐Other:

Authorization Statements/Signatures

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that ifI revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. Unless I specify differently, this authorization will expire (insert date or event):

_____

4. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

Distribution of copies: Original to patient's Health record, copy to patient.