

**ROCKFORD AMBULATORY SURGERY CENTER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Patient Name: _____

Current Address: _____

Date of Birth: _____ Telephone: _____

I HEREBY AUTHORIZE AND REQUEST ROCKFORD AMBULATORY SURGERY CENTER TO RELEASE OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:

(check as applicable)

- Entire medical record
- Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
- Physician notes
- Results of relevant diagnostic or laboratory tests.
- Other _____

HEALTH INFORMATION RELATING TO THE FOLLOWING TREATMENT OR TIME PERIOD:

From _____ (date) to _____ (date).

THE INFORMATION MAY BE RELEASED OR DISCLOSED TO:

FOR THE PURPOSE (S) OF: _____

EXPIRATION: Unless revoked, this Authorization will expire on the following date, event, or condition: _____.

PLEASE READ THE FOLLOWING CAREFULLY:

I *understand* that, as set forth in the Rockford Ambulatory Surgery Center's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Rockford Ambulatory Surgery Center
1016 Featherstone Road
Rockford, IL 61107
ATTN: Privacy Officer

ROCKFORD AMBULATORY SURGERY CENTER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I *understand* that, with certain exceptions, health care providers and others may not condition treatment, payment, or enrollment or eligibility for health plan benefits, on obtaining an authorization.

I *understand* that if I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for the underlying services. A revocation is not effective to the extent that the ASC has relied on the use or disclosure of the protected health information.

I *understand* that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I *understand* that Rockford Ambulatory Surgery Center will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I *understand* that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and or information, and that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.

I *hereby release and hold harmless* Rockford Ambulatory Surgery Center, and their respective staff, providers, directors, officers, employees, agents, successors assigns and attorneys, from and against any and all liability, damages, claims, or suits, including reasonable attorneys' fees, in connection with the disclosure or use of the information as identified above.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority