ANDREWS INSTITUTE
AMBULATORY SURGERY CENTER

Place Patient Label Here

# Authorization for Release of Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's written consent. Please indicate below your wishes regarding release of medical information. Signing this form will only give information to those indicated below.

☐ I authorize Andrews Institute Ambulatory Surgery Center to release my medical information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

*The verbal password the above listed individuals must use to obtain my medical information is:*

_____

☐ I do not authorize Andrews Institute Ambulatory Surgery Center to release my medical information to anyone other than as necessary for treatment payment and health care operations.

**Patient Information**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

I understand I have the right to revoke this consent in writing.

Signature: _____ Date: _____

Witness: _____ Date: _____