GRANTS PASS SURGICAL ASSOCIATES P.C.

1600 NW 6th St., North Suite
Grants Pass, Oregon 97526
Phone 541-474-5533
Fax 541-476-2380

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I understand, and agree, that Grants Pass Surgical Associates, P.C. will use and disclose protected information about me including information that is created and received by the practice. This information may be in written, electronic, or spoken form as necessary for providing health care services, for payment of health care bills, to support the operation of the practice, and any other use required by law.

I understand that I have the right to receive and review a written description of how Grants Pass Surgical Associates, P.C. intends to handle my protected information and my associated rights. This description is known as the HIPPA NOTICE OF PRIVACY PRACTICES. I also understand that the HIPPA Notice of Privacy Practices may, on occasion, be revised and I am entitled to receive a copy of such revisions.

Additionally, I understand that I have the right to ask that some or all of my protected information not be used or disclosed in the manner described in the HIPAA Notice of Privacy Practices, and that Grants Pass Surgical Associates, P.C. is not required by law to agree to such requests. I understand and agree that this information will only be disclosed if I place my initial in the box in the applicable space type of information below.

_____ HIV/AID Information
_____ Genetic Testing Information
_____ Mental Health Information
_____ Drug/alcohol diagnosis, treatment, or referral information

HOW MAY WE CONTACT YOU?

May we leave a message at your home? ☐ Yes ☐ No ☐ N/A

May we leave a message on your cell phone? ☐ Yes ☐ No ☐ N/A

TO WHOM MAY WE DISCLOSE INFORMATION?

Please list all family members, other person(s), or organizations to whom information may be disclosed:

_____ _____

_____ _____

INFORMATION INCLUDED IN THIS AUTHORIZATION

☐ Medical ☐ Financial ☐ Appointments

You have the right to terminate or revoke authorization by submitting a written revocation to Grants Pass Surgical Associates, P.C.

SIGNATURE

I have read this authorization and understand it.

Print Patient's Name _____

Patient's Signature _____ Date _____

Patient Representative _____ Date _____

Description of Authority _____