AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Phone: 831-464-9962
Fax: 831-464-9933

I understand that Surgical Associates of Monterey Bay will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

____
Name of Disclosing Party

____
Address

____
City State Zip Code

To disclose to:

____
Name of Recipient

____
Address

____
City State Zip Code

Records and Information pertaining to:

____
Name of Member/Patient

____
Date of Birth

____
Address City State Zip

____
Telephone Number

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature unless otherwise specified.___________________________
Dates

Revocation: This authorization is also subject to written revocation by the member/patient at any time and written revocation will be effective upon receipt.

Specify Records: Check the box and sign to specify which type of information is to be disclosed:

Lab test results_________ Office notes/exams________ Radiology reports_______________
Date(s) Date(s) Date(s)

Operative reports_________ Hospital records___________ Other___________________
Date(s) Date(s) Date(s)

I understand that I have a right to receive a copy of this authorization upon request. I also understand that this authorization may be modified or withdrawn, but that this modification will only be effective when delivered in writing to Surgical Associates of Monterey Bay.

A copy of this authorization is as valid as the original. Member/Patient has a right to a copy of this authorization.

______________________ ____
Date Signature