

St. Clair Surgical Specialists, P.C.
PATIENT AUTHORIZATION

I hereby authorize you to use and/or disclose the specific information described below, only for the purposes and parties also described below.

Please list the physicians and family members that your protected health information may be released to: (your PHI will only be release to the person (s) named below) and your insurance company.

This authorization shall remain in effect from the date signed below until December 31, 2009

I understand that:

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office in writing, attn: Tina Jenkins, Privacy Officer at 19229 Mack Avenue, Suite 38, Grosse Pointe Woods, MI, 48236.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

Patient/guardian signature: _____ Date: _____

Relationship to patient (if signed by personal representative of patient) _____

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Patient/guardian signature: _____ Date: _____

You have a right to have a copy of this form after you sign it.

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Updated 12/08

Beaumont Hospital of Grosse Pointe Release Form

I hereby authorize St. Clair Surgical Specialists, M.D., to access medical information regarding me that is generated by Beaumont hospital facilities information network. This authorization includes all information-past, present and future.

Patient (Parent if Minor) Signature

Date