SURGICAL ASSOCIATES, LLP
GRINNELL

RELEASE OF MEDICAL INFORMATION

On_____(today's date) I give Surgical Associates LLP at 122 4th Avenue, Grinnell, IA permission to release information regarding (describe issue/surgery/problem that will allow Surgical Associates to give information about)_____ to the place of employment/individual/agency (whom Surgical Associates can give this information too)_____. This information can only be used for the following purposes_____ (FMLA, workers compensation, health insurance).

I understand that this release is valid up to one year from the date I sign it. I understand that I may refuse to sign this authorization and not allow the release of information. I may choose at any time to revoke this authorization. If I do revoke or refuse to sign this authorization I understand that it will not affect my ability to get treatment or my eligibility for benefits. If I do revoke my authorization, it will take effect on the day it is received by the individual agency I name above.

As a patient, I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of the copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, a health plan or a healthcare clearinghouse covered by the federal privacy regulation or is not a business associates of these entities, the information described above will not and may not re-disclosed and continues to be protected under the federal privacy regulation.

Signature of Patient/Guardian/Legal Representative Date signed

FOR INTERNAL OFFICE USE ONLY:

DATE RECEIVED _____ ☐ PAID

PLEASE FAX PAPERS TO:_____