Minor & James Surgical Specialists

A DIVISION OF PROLIANCE SURGEONS

Patient Name: _____

Date of Birth: _____

Authorization to Leave Personal Health Information by Alternate Means

This authorization grants permission to the Designated Party(ies) named below to exchange my private medical information with Minor & James Surgical Specialists, a division of Proliance Surgeons and any authorized representative thereof, without restriction in terms of content, purpose, or means of transmission. This authorization includes, but is not limited to: making or confirming appointments; accessing any and all x-ray, laboratory, or test information; access to telephone communication and answering machine messages as well as other common means of communication; be made aware of my diagnosis, prognosis, and treatment plans; direct discussion of my health with my doctor or other provider; and have access to my financial information as it relates to my health.

Designated party: _____ Relationship: _____

Designated party: _____ Relationship: _____

☐ May leave detailed voicemail messages for the patient at the following phone number(s): _____

_____

I understand that providing this authorization is voluntary. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand that it is my responsibility to notify my healthcare provider should I amend one or more of the designated parties listed above. I understand that once this information is disclosed to the Designated Party(ies), the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Minor & James Surgical Specialists in writing. If I do revoke the authorization, it will not have any effect on any actions taken by Minor & James Surgical Specialists prior to receipt of the revocation.

☐ Authorization will expire 1 year from the date signed by the patient or the patients representative; or

☐ Authorization is effective for the lifetime of the patient unless revoked in writing.

_____ _____

Signature of Patient or Guardian Relationship to Patient

_____ _____

Printed Name Date