ADVANCED SURGICAL ASSOCIATES, P.A.
530 NEW WAVERLY PLACE, SUITE 304
CARY, NORTH CAROLINA 27518
(919) 851-9193 FAX (919) 851-9223

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Check the appropriate boxes to indicate how we may release your health information.

□Answering Machine/Voice Mail
Information to be disclosed: **□ Medical Information**
□ Date/Time of Office Visit **□ Office visit Instructions**
□ Date/Time of Surgery **□ Surgery Instructions**
□ Request for additional information **□ Financial**

□ Visit my waiting party after my surgery and give a status report
Or
□ Do not visit anyone in the waiting area after my surgery to give a status report.

□ Spouse
Information to be disclosed:
□ Medical **□ Financial** **□ Exceptions_____**

□ Parent
Information to be disclosed:
□ Medical **□ Financial** **□ Exceptions_____**

□ Other (name/relationship):_____
Information to be disclosed:
□ Medical **□ Financial** **□ Exceptions_____**

Advanced Surgical Associates, P.A. is authorized to release health information about the patient listed below as directed by the information filled out in this form. Release of information is for the direct purpose of informing the patient and/or others designated by the patient about the patient's health status as per the patient's instructions.

PRINT NAME_____ DOB_____/_____/_____

I understand that I have the right to revoke this authorization at any time. I have the right to inspect or copy my health information. To receive a copy of my health information I must submit a written request to Advanced Surgical Associates, P.A. Information redisclosed by myself or others I have designated may no longer be protected under Federal or State law. I may refuse to sign this authorization without any consequences to my health care treatment. Once signed, the authorization will remain in effect until a written request that it be revoked is submitted to Advanced Surgical Associates, P.A.

SIGNATURE_____DATE_____

REV. 3/07