Proliance®
Puyallup Surgeons

Authorization To Disclose Health Information

NOTICE:
*Federal law says that Proliance Puyallup Surgeons, A Division of Proliance Surgeons, Inc. and Proliance Puyallup Surgery Center (PSC and PASC) cannot share your health information without your permission except in certain situations. If you sign this form, you are giving PSC and PASC permission to share your health information that PSC and PASC has with the person you indicate below.

*This authorization is voluntary.

*Right to revoke: If you decide you do not want PSC and PASC to share your health information any longer, sign the revocation at the end of this form and give this form to PSC. If PSC and/or PASC has shared your health information for a research study, PSC and/or PASC may continue to use or share your health information for that purpose only.

*Payment, enrollment, or eligibility for benefits for your health care will not be affected if you do not sign this authorization.

*PSC and PASC cannot promise that the person you permit PSC and PASC to share your health information with will not share your health information with someone else you may not want to have your health information.

MY NAME: _____ **Date of Birth**: _____

I give permission to: Puyallup Surgical Consultants A Division of Proliance Surgeons, Inc. and Puyallup Ambulatory Surgery Center to share my health information with: (any people of your choice, family, friends etc.)

➡ _____

So that this person or entity may assist with my health care issues. PSC and PASC may share my health information for one year after the date on this authorization form or until I revoke the authorization.

I want Puyallup Surgical Consultants and PASC to share this health information: (Check all that apply)

_____ All of my health information _____ Information regarding prescription drug coverage _____ Other

_____ My health information regarding treatment for alcohol and/or substance abuse

_____ My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

This form must be signed by either THE RECIPIENT or BY THE PERSONAL REPRESENTATIVE. The recipient's parent may sign for the recipient if they are a minor.

➡ _____

Signature of Patient Date

If this form is signed by the personal representative, please include a copy of the document name the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointment a guardian.

_____

Signature of Personal Representative Relationship of Personal Representative Date

OR
REVOCATION OF AUTHORIZATION
I no longer want Puyallup Surgical Consultants a division of Proliance Surgeons, Inc. and Puyallup Ambulatory Surgery Center to share my health information with the person or entity indicated above.

_____

My Name (Printed) Signature Date