



AUTHORIZATION FORM

PATIENT'S FIRST & LAST NAME: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

PHONE NO. (H) : _____ (W): _____

Social Security Number ____ - ____ - ____

This is an authorization under the Privacy rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR para 164.508]. It authorizes Christiana Institute of Advanced Surgery to use/disclose my medical records to (i.e. primary care physician)

The person / people authorized to make this use/disclosure are:

CHRISTIANA INSTITUTE OF ADVANCED SURGERY

Under the Privacy Rules, I have the right to revoke this authorization at any time, and Christiana Institute of Advanced Surgery must cease using this authorization. However, Christiana Institute of Advanced Surgery may complete any actions it initiated prior to my revocation and which rely on my medical records for completion.

I understand that by disclosing my medical records, Christiana Institute of Advanced Surgery cannot guarantee the recipient will use or disclose in violation of the Privacy Rules.

I must revoke this authorization in writing and send the revocation to Christiana Institute of Advanced Surgery, 537 Stanton-Christiana Rd., Suite 102, Newark, DE 19713.

Please print name of Patient _____

Date _____ Signature _____

or

Name of Representative of Patient _____

Date _____ Signature _____