

Surgery Group of Grand Island

PATIENT AUTHORIZATION FORM TO RELEASE INFORMATION TO FAMILY MEMBERS

Patient Authorization for Disclosure of Protected Health Information

I, _____, hereby authorize Surgery Group of Grand Island to:

Disclose the following protected health information to:

Please list below the name(s) of individual(s) to disclose information. **NOT PHYSICIANS, CLINICS, HOSPITALS OR OTHER HEALTHCARE PROVIDERS**

Specifically describe the Protected Health Information to be disclosed including, but not limited to, meaningful descriptors such as: date of service, type of service provided, level of detail to be released, origin of information, etc. **If any and all information is to be disclosed, please state "Any and all Information"**

This authorization shall be in force and effect until advised otherwise in writing by the Patient or Personal Representative at which time this authorization to disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Ann McMickell at Surgery Group of Grand Island 820 North Alpha P.O. Box 5226 Grand Island, NE 68802.

I understand that a revocation is not effective to the extent that Surgery Group of Grand Island has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Patient Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority