



INDIO SURGERY CENTER

providing
Children's Dentistry
under General Anesthesia

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: ____/____/____

MR# Number: _____

Organization providing the information

Organization receiving the information

Specific description of the information (including date(s) of healthcare) to be disclosed:

This authorization shall be in force and effect until: (check one of the following)

- Date: _____
- The happening of the following event:

- End of research study at which time this authorization to use or disclose this protected health information expires.
- No expiration (can only be used if authorization is for creation of research database or research repository.)

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Indio Surgery Center
46-900 Monroe Street, Indio, CA 92201
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that the Indio Surgery Center 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.

Check One of the Following:

- I understand that the Indio Surgery Center will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that the health care provided by the Indio Surgery Center is solely for the purposes of creating protected health information **for** _____ **(insert third party name)** and that my authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the Indio Surgery Center will not provide health care services to me.
- I understand that the treatment being provided by the Indio Surgery Center is related to research and that my authorization of disclosures for research related purposes is a condition of this



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treatment. I understand that if I do not sign this authorization, then the Indio Surgery Center will not provide research related treatment to me.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority