Verbal Disclosure of Health Information Authorization

I, ________________ ________, authorize Specialists in General

Patient Name **DOB**

Surgery, to disclose the following medical information:

☐ ALL

☐ Scheduling/Appointment information

☐ Medical Information/Results

☐ Billing/Payment Information

☐ Other (describe): ________________

Specialists in General Surgery has my permission to disclose the above information to the following recipient(s):

Name (first and last)	Relation	Phone Number

I understand that I have the right to revoke this authorization at any time by sending a written request for revocation to Specialists in General Surgery. **I understand this authorization remains in effect until the time I revoke it in writing.** If I revoke this authorization, Specialists in General Surgery, will no longer disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Specialists in General Surgery discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

Authorization valid until revoked in writing by the patient/authorized representative.

________________________________ ____________

Patient/Authorized Representative Signature **Date**

If other than patient, state relationship and authority to sign ________________