PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

I authorize the following person(s) to obtain and/or disclose protected health information (PHI) about me.

Name: Address: Phone: Relation:

By signing below, I understand this authorization permits Monterey County Surgical Associates to use and/or disclose the following identifiable health information about me. I also understand that this can be revoked in writing at any time.

- Appointment History and Scheduling Appointments only
- Requesting records on my behalf only
- All matters related to my patient chart
- All matters related to my patient chart except:

- Only this information:

This authorization is valid: (Give dates)

From : To:

-OR-

- This authorization is valid until I revoke it in writing

Patient Name: Date of Birth:

Signature: Date: