

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**Information to be Used or Disclosed**

The information covered by this authorization includes:

**ALL MEDICAL INFORMATION (Cross out if not wanted)**

**ALL BILLING INFORMATION (Cross out if not wanted)**

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Persons Authorized to Use or Disclose information

Information listed above will be used or disclosed by:

**Wyoming Surgical Associates**

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Name of person or organization

Persons to Whom Information May Be Disclosed (**Other Doctors, your family members, significant others, friends or no one at all**)

Information described above may be disclosed to:

**X**

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Name of person or organization

**X**

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Name of person or organization

**DURATION:**

**THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL REVOKED.**

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Wyoming Surgical Associates, P.C. You should contact our Compliance Officer to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**X**

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Name of patient (Print or type)

**X**

**X**

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Signature of Patient

Date

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Signature of Patient Representative

Date

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Relationship of Patient Representative to Patient