STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

To: Wyoming Surgical Associates, PC

I,_____ hereby authorize your organization to release the
Name of patient
Following personal health information:

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

To the following people (list names and relationship):

1. _____
2. _____
3. _____
4. _____
5. _____

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	X
Signature of Patient or Guardian	Date