Suburban Surgical Associates, Inc.

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General and Laparoscopic Surgery

Lawrence G. Mendelow, M.D., F.A.C.S.
Colon and Rectal Surgery

G. Paul Yazdi, M.D., F.A.C.S.
Oncologic Surgery

Eric D. Lederman, M.D., F.A.C.S.
Colon and Rectal Surgery

Brent T. Allen, M.D., R.V.T., F.A.C.S.
Vascular Surgery

Todd K. Howard, M.D., F.A.C.S.
General and Hepatobiliary Surgery

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General and Vascular Surgery

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Colon and Rectal Surgery

Michael D. Weiss, D.P.M., F.A.C.F.A.S.
Podiatric Surgery

Nicolas C. Martin, D.P.M.
Podiatric Surgery

Jeane L. Stohldrier, P.A.-C
Vascular Surgery

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Section 1

Patient Authorization to Use or Disclose Protected Health Information
Acknowledgement of Notice of Privacy Practices

I, _____, understand Suburban Surgical Associates, Inc is authorized by me to use or disclose my protected health information for purpose of treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipients(s) of that information. I specifically authorize a current employee of Suburban Surgical Associates, Inc or any other individual listed below to disclose my protected health information. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Section 2

Yes ☐ No ☐ Suburban Surgical Associates, Inc., may acquire and/or disclose medical records to/from any and all physicians, hospitals, and other medical institutions.

Yes ☐ No ☐ May we leave test results/messages on answering machine.

If yes, please list phone number for messages: _____

Section 3

Name(s) of person(s) authorized by this form to use and disclose the patient's protected health information: example (spouse, child, parents)

_____

_____

I fully understand and accept the terms of this authorization and I have received the Notice of Privacy Policies.

_____ _____

Patient's/ Guardian Signature Date