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

**Section 1**

I \_\_\_\_\_, understand Suburban Surgical 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 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.

**Section 2**

Yes  No  Suburban Surgical 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

\_\_\_\_\_  
**\*\*Appointment\*\* Date**