CRIGHTON OLIVE DUNN
SURGICAL GROUP INC.

Authorization to Use/Release Protected Health Information ("PHI")

PHI is individually identifiable health information that could be used to identify me and relates to my physical or mental condition, provision of care for the condition or payment for such care. The PHI used/released may include, but is not limited to, my name, address, age, date of birth, health plan ID number, Social Security number, and other related medical records:

I, the undersigned, authorize Crighton Olive Dunn Surgical Group Inc. to:

□ Release information to □ Obtain information from

Name: _____

Address: _____

_____

Crighton Olive Dunn Surgical Group Inc. may use/release the following type of PHI:

□ Consultation report □ Admit/Discharge Summary □ Radiological reports □ Lab results
□ Operative report □ Complete health record □ Complete billing record □ Other _____

Information to be released is from the periods of health care:

From *date*: _____ to *date*: _____

I am aware that my authorization to use/release this information is effective immediately and valid for twelve (12) months from my signature date. I have the right to amend or cancel this authorization at any time by providing written notice to Crighton Olive Dunn Surgical Group Inc. at the address listed below. However, my amendment or cancellation does not apply to any PHI previously used or released based on reliance on this authorization made prior to Crighton Olive Dunn Surgical Group Inc.'s receipt of my amendment or cancellation.

I am aware that if my PHI is used or released to an entity that is not required to follow state or federal privacy or security regulations or laws, my released PHI may no longer receive the same level of protection as provided by Crighton Olive Dunn Surgical Group Inc. Any services otherwise provided to me by Crighton Olive Dunn Surgical Group Inc. will not be affected by my decision to provide this authorization. I may refuse to sign, and Crighton Olive Dunn Surgical Group Inc. will not condition my treatment or payment on my decision to sign/not sign this authorization form.

By signing this authorization form, I hereby authorize Crighton Olive Dunn Surgical Group Inc. to use / release all of my health information contained in my patient profile or medical records as described above.

Patient Name: _____ Relationship to Patient: _____

Patient Address: _____ Date of Birth: _____

_____ Social Security #: _____

Signature: _____ Date: _____

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