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GENERAL SURGERY
ASSOCIATES

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HIPAA Authorization for the Use and Disclosure of Protected Health Information

To authorize General Surgery Associates, P.C. to discuss your protected healthcare information (PHI) or financial information with someone other than yourself, please fill in the below information. You may revoke your consent in writing at any time. However, your revocation will not be retroactive.

I, _____(patient's name), give **General Surgery Associates, P.C.** permission to release/discuss personal medical and/or financial information to/with:

_____	_____	_____
Name of person we can release info to	Relationship to patient	Phone number
_____	_____	_____
Name of person we can release info to	Relationship to patient	Phone number
_____	_____	_____
Name of person we can release info to	Relationship to patient	Phone number
_____	_____	_____
Name of person we can release info to	Relationship to patient	Phone number

If you **DO NOT** wish to give authorization to General Surgery Associates, P.C. to discuss your protected healthcare information (PHI) or financial information with someone else, please acknowledge below:

I, _____(patient's name) **DO NOT** wish to give General Surgery Assoicates, P.C. permission to release/discuss my personal health information and/or financial information to/with anyone othr than myself.

_____	_____
Print Patient's Name	Patient's Date of Birth
_____	_____
Signature of Patient or Legal Guardian	Date of Signature

Effective Date of This Notice: 5/30/2025