Patient: _____ Date of Birth: _____ SS#: _____

Stark Ambulatory Surgery Center, L.L.C.
4360 Fulton Dr., N.W. Suite C
Canton, Ohio 44718
Fax #: 330-305-9090

Patient Authorization to Use or Disclose Protected Health Information

This authorization permits _____ to send the protected health information ONLY to this address or fax number:

_____
_____
Any other address or fax number is not permitted by this authorization.

I, _____, understand _____ is authorized by me to use or disclose my protected health information for a purpose other than 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 this information, and the recipients(s) of that 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 and I retain the right to revoke this authorization.

Description of the information to be used or disclosed (check all that apply):

Medical Data/Information as related to:

[ ] The patient's entire medical record.
(Note: This requires an explanation why the entire record may be disclosed)
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

Purpose(s) of the disclosure:

_____
_____

Insurance Change **New Insurance Company**

This authorization is to be used for our own use, and Stark Ambulatory Surgery Center, L.L.C. and affiliates will not condition treatment or payment on this authorization. Moreover, the patient has the right to receive a copy of the information to be used or disclosed and may refuse to sign this authorization. A fee may be assessed for copies requested.

This authorization for release of information is valid for 60 days from the date of signature, unless revoked by a written notice to the providing institution, providing said notice is received prior to release of the information.

If you wish to revoke this authorization, please refer to the Notice of Information Practices.

_____ _____
Responsible Party's Signature Date

Refusal to provide your signature will result in the non-release of protected health information.