Date ________________

Authorization for Release of Patient Information

Name of Patient _________________________ Date of Birth _____________

Wake Surgical Specialists is authorized authorized to release protected health information pertaining to the above named patient to the entities below.

Entity to Receive Information (*Initial each that is subject to this information*)

_____ Leave information on voice mail _______ Give information to spouse

_____ Give information to the following persons: ______________________ ____________
Relationship

_____ Employer FMLA/Disability Insurance

Description of Information to be Released (*Initial each that is appropriate)*

_____ Financial Information
_____ Results from tests and/or x-rays
_____ Family Billing Information
_____ Disability Insurance/FMLA Forms/Medical Insurance
_____ Medical Information as follows: ____
_____ Other information as described: ____
_____ I **do not** authorize the release of any information at this time.

Rights of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as describe in this document by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal and State Law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.
This authorization shall be in force and effect until revoked by the patient or representative sighing the authorization.

______________________________________ ___________________
Signature of Patient or Personal Representative Date

____

Health Insurance Portability and Accountability Act

Confidentiality Policy

POLICY

Wake Surgical Center is entrusted by its patients and required by law to ensure the security of individually identifiable health information. This protected health information is preserved by law and regulatory requirements and these laws and regulatory requirements to be upheld by each individual involved with this organization.

- We are subject to the compliance of the law as we are a health care provider and we maintain and transmit health information in electronic form in connection with transactions referred to as claims, encounters, eligibility, referrals, payments, electronic remittance, coordination of benefits, claim status, first report of injury, health claim attachments and any other transactions as the Secretary may prescribe by regulation.

- We are permitted to use and disclose protected health information for the purpose of treatment, payment and health care operations.

- We shall make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.

- When making disclosures to public officials we will reasonably rely on the representations of such officials that the information requested is the minimum necessary for the stated purpose(s).

- We may use or disclose any de-identified protected health care information provided that the key or other devices designed to enable coded or otherwise de-identified information is not used or provided.

- We recognize all individually identifiable health information identifiers as created, received and used within our electronic computer systems and will make every reasonable effort to ensure they are secure in our environment. These identifiers are listed as:

  Name, address (street, city, county, zip code, geocode), names of relatives, names of employers, birth date, telephone numbers, fax numbers, social security number, medical record number, account number, health plan beneficiary number, certificate or license number, E-mail address, IP address, vehicle or other device serial number, Web URL, finger or voice prints, photographic images, and any others added by the Secretary in future regulations

- The death of a patient does not terminate his rights to protection of health information. We shall apply all reasonable efforts to protect the individually identifiable health information of a deceased individual in the same manner we protect the living. This policy shall be in effect for two years following the death of the individual.

- I give my physician permission to communicate health information via my answering machine or voicemail.

Signature: ____ Date: ______________________

By signing above, I acknowledge receipt of the privacy policy as outlined by the Health Insurance Portability and Accountability Act. A general notice of privacy practices is available on request.