ANESTHESIA ASSOCIATES OF LANCASTER, LTD.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Read entire document before signing

This authorization gives Anesthesia Associates of Lancaster, Ltd. permission to use and/or disclose health information about you.

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by us, except we may condition treatment on signing this authorization permitting disclosure to the third party in the case of health care that is solely for the purpose of creating protected health care information for disclosure to a third party (for example, a pre-employment physical), or if your protected health information is created for research that includes treatment of you.

Right to revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

Anesthesia Associates of Lancaster, Ltd.
Attn: Privacy Officer
133 East Frederick Street
Lancaster, PA 17602

Re-disclosure. Health information disclosed pursuant to this authorization may be subject to re-disclosure and may be no longer protected by the federal privacy rule or another privacy law, or by this authorization.

Authorization of Uses and Disclosures

Please print all information except signature

1. Patient name:_____

2. Covered health information to be used/disclosed [Describe in a specific and meaningful fashion]
   _____
   _____
   _____

3. Identity of user/discloser [Provide the name or other specific identification of the person(s) or class of persons authorized to make the requested use and/or disclosure]
   _____
   _____
   _____

4. Authorized action(s): G uses G disclosures (check one or both boxes, as applicable

5. Identity of recipient [Provide the name or other specific identification of the person(s) or class of persons to whom we may disclose the covered information.*]

_____
_____
_____

* Not necessary if only uses are authorized

6. Each purpose of the authorized uses and disclosures:**

_____
_____
_____

** "At request of individual" is sufficient for uses and disclosures initiated by the patient who does not, or elects not to, provide a statement of the purpose.

7. Expiration of authorization [Provide a date or event that relates to the patient or the purpose of the use and/or disclosure]

_____
_____
_____

8. You may disclose protected health information which includes confidential psychiatric information (excluding psychotherapy notes, which are subject to a separate authorization), drug and alcohol information, and HIV related information. **[strike out if such disclosure is not authorized]**

I have read and understand this authorization, and authorize use and disclosure of health information about the named patient as described in this authorization. I acknowledge receipt of a copy of this authorization.

_____ _____

Signature of patient
(or patient's personal representative)

Date of receipt

Personal representative information (if applicable):

_____

Name of personal representative

_____

Relationship to patient (or other authority)