USE OR DISCLOSURE PATIENT AUTHORIZATION

I, _____, hereby authorize Cypress Surgery Center ("Facility") to use or disclose my protected health information as described in this form.

The following information may be used and disclosed:
(Specifically describe the information to be used and disclosed, including meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____
_____
_____
_____
_____
_____
_____

The Facility may disclose this protected health information to:
(Insert name of person or entity who may receive the information.)

_____

This protected health information is being used or disclosed for the following purposes: (*List specific purposes here, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request, simply check the box below.)*

_____
_____
_____

At Patient's Request

This authorization shall be in force and effect until: (check **<u>one</u>** of the following)

- ❑ Date _____
- ❑ The happening of the following event:
  _____
  _____
- ❑ End of research study at which time this authorization to use or disclose this protected health information expires.
- ❑ No expiration (can only be used if authorization is for creation of research database or research repository.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Cypress Surgery Center
9300 E. 29th St. N. Suite 100
Wichita, KS 67226

ATTN: Privacy Officer/Administrator

I understand that a revocation is not effective to the extent that the Facility has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the Facility will not condition treatment, payment, enrollment in a health plan or program, or eligibility for benefits on whether I provide this authorization.

I understand that if the Facility requested this authorization, the Facility must provide me with a copy of this form once it has been signed. I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

[A copy of the signed authorization should be provided to the patient. If this authorization is being requested by the Facility for its own purposes, the Facility <u>must</u> provide the patient with a copy of the signed authorization.]