DSS
Desert Surgical Specialists

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please answer the following three questions regarding the release and disclosure of your medical and billing information.

1. Do we, Desert Surgical Specialists, PLLC, have your permission to release your medical information to all of your healthcare providers and insurance companies? ☐ Yes ☐No

2. Do we, Desert Surgical Specialists, PLLC, have your permission to obtain your medical information from all of your healthcare providers and insurance companies? ☐ Yes ☐No

3. Please list all family members/guardians who may access your medical records and/or financial and billing information.
   Please list ALL:

Name of Person	Relationship	Medical Only	Billing only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Desert Surgical Specialists, PLLC, Attn: HIPPA compliance Officer, via mail or in person. It will be effective only when Desert Surgical Specialists, PLLC receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
Printed Patient Name Patient's Date of Birth

_____ _____
Signature of Patient Date

_____ _____
Signature of Client/Personal Representative Relationship to Patient

Please note that this form expires one year after signed. You will be asked to complete this form annually.