



Advanced Surgical Associates, P.A.
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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Check the appropriate boxes to indicate how we may release your health information

Answering Machine/Voice Mail

Information to be disclosed:

Date/time of Office visit

Office visit Instructions

Date/time of Surgery

Surgery Instructions

Request for additional information

Financial

Visit my waiting party after my surgery and give a status report

or

Do not visit anyone in the waiting area after my surgery to give a status report

Spouse

Information to be disclosed:

Medical

Financial

Exceptions: _____

Parent: _____

Information to be disclosed:

Medical

Financial

Exceptions: _____

Other(name/relationship): _____

Information to be disclosed:

Medical

Financial

Exceptions: _____

Do not release any of my health information other than directly in my presence

Advanced Surgical Associates, P.A. is authorized to release health information about the patient listed below as directed by the information filled out in this form. Release of information is for the direct purpose of informing the patient and/or others designated by the patient about the patient's health status as per the patient's instructions.

Name: _____ **DOB:** _____ / _____ / _____

I understand that I have the right to revoke this authorization at any time. I have the right to inspect or copy my health information. To receive a copy of my health information I must submit a written request to Advanced Surgical Associates, P.A. Information redisclosed by myself or others I have designated may no longer be protected under Federal or State law. I may refuse to sign this authorization without any consequences to my health care treatment. Once signed, the authorization will remain in effect until a written request that it be revoked is submitted to Advanced Surgical Associates, P.A.

Signature: _____ **Date:** _____ / _____ / _____