Northwest Iowa P.C.
Surgeons

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Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Northwest Iowa Surgeons, PC

Information to Be Disclosed
Information to be obtained under this authorization includes:

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Purposes of Disclosure
Information listed above will be disclosed for the following purposes:

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Persons Authorized to Disclose Information
Information listed above will be disclosed by:

____
Name of Person/Organization

____
Address/Phone/Fax

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

____
Name of Person/Organization

____
Address/Phone/Fax

Expiration Date of Authorization
This authorization signed today is effective through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **Northwest Iowa Surgeons, PC.** You should contact the **office manager** to terminate this authorization.

Potential for Redisclosure
Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual
- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

____
Name of Patient (Print or Type)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

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