Fayette Surgical Associates
1401 Harrodsburg Road, Suite C-100
Lexington, KY 40504
Phone: (859) 278-4960
Fax: (859) 278-0033

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth: _____ (for identification purposes)

I give Fayette Surgical Associates permission to **discuss** my **entire medical record** and **billing information** with the following specified persons.

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____

OR

Please **discuss only the following specified information** with the above-named persons:

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such notification to Fayette Surgical Associates.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding privacy of my protected health information.

This authorization expires on _____

Signature of patient/representative _____ Date _____

Witness Signature _____ Date _____