MIDWEST CENTER FOR DAY SURGERY
USE OR DISCLOSURE AUTHORIZATION

[NOTE: This form not to be used for marketing purposes.]

I, _____, hereby authorize Midwest Center for Day Surgery to use or disclose the following protected health information:
(Specifically describe the information to be used or disclosed, including meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____
_____
_____
_____
_____
_____
_____

The protected health information may be disclosed 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.)*

_____
_____
_____

This authorization shall be in force and effect until: (check one 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, as set forth in the Midwest Center for Day Surgery's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Midwest Center for Day Surgery
3811 Highland Avenue
Downers Grove, IL 60515
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that the Midwest Center for Day Surgery 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 Midwest Center for Day Surgery will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- 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 Midwest Center for Day Surgery for its own purposes, the Midwest Center for Day Surgery must provide the patient with a copy of the signed authorization.]