PEDIATRIC
SURGICAL ASSOCIATES
GENERAL, THORACIC & MINIMALLY INVASIVE SURGERY
every child deserves our best

Daniel A. Bambini, MD
Andrew M. Schulman, MD
Graham H. Cosper, MD
Thomas M. Schmelzer, MD
Nicholas E. Bruns, MD
Jessica M. Pierce, PNP-AC
Abigayle L. Price, PA

Metroview Professional Building
1900 Randolph Road, Suite 210
Charlotte, NC 28207
Telephone 704/370-0223
Fax 704/370-0799
www.pedsurgical.com

Duncan Morton, Jr., MD
Emeritus
Robert J. Attorri, MD
Emeritus
Amy J. Combs
Administrator

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164)("HIPAA Privacy Rules"). This authorization affects your rights in the privacy of your personal health information. Please read carefully before signing.

(Please Print)

Patient's Name:_____ Patient's DOB:_____

Patient Account Number:_____

I request and authorize Pediatric Surgical Associates, P.A. to release personal health information on the patient named above to the following representative:

Name:_____Contact Phone: _____

Address:_____Fax: _____

This request and authorization applies to all information concerning the case history, treatment and examinations, including copies of hospital and medical records, of the patient named above relating to the approximate period of time from _____ to the present.

I understand that I may revoke this request and authorization, in writing, at any time. Any exceptions to this right to revoke, and a description of how this request and authorization may be revoked, are included in the HIPAA Privacy Notice prepared by Pediatric Surgical Associates and provided to me.

I understand that my refusal to sign this authorization will not adversely impact the treatment, payment, enrollment or eligibility for benefits in a health plan of the patient named above.

I understand that once Pediatric Surgical Associates, P.A. discloses information pursuant to this request and authorization, Pediatric Surgical Associates has no further control over the use or disclosure of that information.

_____ _____
Signature of Patient or Patient's authorized representative ***Date***

_____ _____
Relationship or status if signed by Patient's authorized representative (i.e. Parent, Legal Guardian, etc.) ***Signature of Witness***

_____ _____
Address ***Phone***

Updated 08/24/21