

PATIENT AUTHORIZATION FOR DUTCHESS SURGICAL ASSOCIATES TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Dutchess Surgical Associates to release Protected Health Information (PHI) to:_____

Address:_____

Specific PHI to be released:_____

This authorization will expire on:_____

Signature of patient/guardian_____

Name of patient_____ Date of Birth_____

Date_____