



METROPOLITAN
SURGICAL
CENTER

Metropolitan Surgical Center
9645 Grove Circle N, Suite 250
Maple Grove, MN 55369
P: 763.201.8191
F: 763.201.8192

James B. Parmele, MD
Jason S. Wolff, MD
Ronald B. Boeding, MD
Dustin R. Ward, MD
Rano M. Faltas, MD
Jonathan Hagedorn, MD

Patient’s Consent to Disclose Protected Health Information to Authorized Persons

Patient’s Legal Name _____ **Date of Birth** _____

Previous Name _____ **Phone Number** _____

1. **Authorization to Disclose PHI (Protected Health Information).** I hereby authorize you, my healthcare provider (“Provider”), to disclose any and all of my medical and protected health information (“PHI”) to the persons indicated below.

2. **Persons to Whom Disclosure May be Made.** Provider may disclose my PHI to the following persons:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. **Purpose of Disclosure.** The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health, per my request.

4. **Expiration of Authorization.** This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. **Conditioning of Treatment.** Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. **Re-disclosure by Recipient.** I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law.

7. **Acknowledgment of Reading and Agreement.** I have read and understand this authorization.

Patient Signature or Representative

Date

Printed Name

If a Representative Signs, state the Representative’s Authority: _____