GRAND VIEW SURGERY CENTER at HARLEYSVILLE

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HIPAA ACKNOWLEDGEMENT AND HIPPA RELEASE OF INFORMATION AUTHORIZATION FORM

I, the patient and/or my power of attorney, hereby authorize Grand View Surgery Center and its affiliates, its employees and agents to release my personal health information maintained by my operating Physician and Grand View Surgery Center of Harleysville. Information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, Social Security number, Member ID number for helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire an entire year from the date signed below.

I understand that I have a right to revoke this authorization by providing written notice to Grand View Surgical Center and its affiliates. However, this authorization may not be revoked if Grand View Surgical Center, it's employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I acknowledge that I have received and/or been given the opportunity to review the Grand View Surgery Center's Privacy Notice.