**Arturo G. Gonzalez, MD, FACS**

**General Surgery**

AUTHORIZATION FOR RELEASE OF INFORMATION TO DESIGNATED PERSON(S)

Patient Name: ______________________________________________ Date of Birth: __________

This form is part of the Federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Minimally Invasive & Robotic Surgery, PLLC to release information regarding your healthcare.

***Person(s) who can receive information for you:***

Name: ____________________________________________________ Date of Birth: __________

Name: ____________________________________________________ Date of Birth: __________

Name: ____________________________________________________ Date of Birth: __________

_________________________________________________________________________________

_________________________________________________________________________________

I hereby authorize the staff of Minimally Invasive & Robotic Surgery, PLLC to use and disclose my individually identifiable health information as described above. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations. This authorization shall be in force and effective until you make any changes. It is your responsibility as the patient to update our office with any changes to this form.

_________________________________________________________________ ________________

Signature of patient or patientøs guardian/representative Date

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