



Prairie Surgical Care

Laparoscopic and General Surgery

Carlo Jurani, M.D., F.A.C.S.

8901 W. 74th Street, Suite 312

Shawnee Mission, KS 66204

Phone 913-432-4355 Fax 913-432-5994

AUTHORIZATION TO OBTAIN INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize the following entity to release my personal health and medical information to Prairie Surgical Care, LLC, Carlo C. Jurani, MD LLC

This information should be delivered, mailed, or faxed to the following:

Prairie Surgical Care, LLC

8901 W. 74th Street

Suite 312

Shawnee Mission, KS 66204

Phone 913-432-4355

Fax 913-432-5994

This release will include the following: Entire medical record

Other (specify) _____

The patient or the patient's representative must read and initial the following statements:

I understand: (a) this authorization is voluntary; (b) I may inspect or receive a copy of the information described on this form if I ask for it and that I may have a copy of this form after I sign it; (c) this authorization will expire in one year unless otherwise specified _____.

I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing.

I understand that if the recipient of the information listed above is not a healthcare provider or healthcare plan covered by the federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Signature of patient/guardian/representative Date

If signed by other than patient, indicate relationship

Address and phone number

Printed name of representative