



EXHIBIT B

**PATIENT AUTHORIZATION FOR
RELEASE OF HEALTH INFORMATION**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Patient Name: _____ Social Security Number: _____

Persons authorized to use or disclose the information:

Persons authorized to receive the information:

Specific description of information (including date(s)):

1. Torrance Surgery Center must complete the following:

a. What is the purpose of the use or disclosure?:

b. Will the surgery center receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

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

a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. Initials: _____

b. I understand that I may see and COPY the information described on this form if I ask for it, and that the surgery center will give me a copy of this form after I sign it. Initials: _____

c. I understand that this authorization will expire on ____/____/____. Initials: _____



- d. I understand that I may revoke this authorization at any time by notifying the surgery center in writing, but if I do revoke it, the revocation will not have any effect on any actions the surgery center took before it received the revocation. Initials: _____

Signature of patient or patient's representative

Date

Printed name of patient's representative: _____

Relationship to patient: _____