AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, ______________________________________, hereby authorize Lawrence Surgery Center to release
(Please Print)
copies of my medical record to ____.
(Name and Address of Person to whom information is to be released)

____

Name at time of treatment (if different than above): ____

Purpose for such release of information:

☐ Patient Request ☐ Other: ____

Specific information to be released:

☐ Medical Record from (insert date) ____________________________ to (insert date) __________________________

☐ Entire Medical Record, including operative note, patient history, nursing notes, anesthesia record, test results, radiology studies, referrals, consults, billing records, insurance records, and records sent by other health care providers.

☐ Operative Notes ☐ Anesthesia Record ☐ Electrocardiogram

☐ Other ____ Include: (Indicate by Initialing)

____ _______ Alcohol/Drug Treatment

_______ HIV-related Information

This consent can be revoked but not retroactive to a release of information made in good faith.

Date or condition upon which this Authorization expires: ____
(One year to date unless otherwise noted)

If not patient, name of person signing form: Authority to sign on behalf of patient:

____ ____

Executed this ____ day of ___________, 20____

____ ____

Signature of Patient or Legal Representative Signature of Witness