



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

