Surgery Center of Gilbert

Authorization to Release Medical Record

I,____, authorize the Surgery Center of Gilbert to disclose the following information from the health record of:

PATIENT INFORMATION	Patient Name			Date of Birth	MR#
	Address				
	City	State	Zip	Phone Number	
	Dates of Service: From		To:		
INFORMATION REQUESTED	☐ All Pertinent Records ☐ Assessment(s) ☐ Consultation ☐ Discharge Summary ☐ EKG Report ☐ History & Physical ☐ Operative Report	☐ Pathology Report ☐ X-Ray Films ☐ X-Ray Reports ☐ Billing Record ☐ Photos		☐ Other Specify:	
PURPOSE	☐ Self ☐ Other (specify reason)	☐ Continuing Medical Care		☐ Attorney Request	
INFORMATION TO BE GIVEN TO	Company, Person, Facility			Phone Number	
	Address		City	State	Zip Code

I understand that information in my health record may include information relating to Sexually Transmitted Disease (STD), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I may refuse to sign this authorization form. I understand that Surgery Center of Gilbert will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Surgery Center of Gilbert's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, it will expire in six (6) months from the date signed or as specified:___________________.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Surgery Center of Gilbert, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health decisions.

Signature of Legal Representative

Relationship to Patient **or** Description of Authority to Act for Patient

(Must attach a legible copy of a photo ID)