GREAT LAKES SURGERY CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION OF

The following will be completed by the patient or the patient's authorized representative		
Patient Name: (Please Print)	**DOB**	**Telephone:**

I hereby authorize:

_____

Name of provider who is to release information

_____

Address of provider who is to release information

To release the following protected health information contained in my medical record regarding my care and/or treatment between the following dates: _____ to _____ to:

_____

Name of provider who is to receive information

_____

Address of provider who is to receive information **Fax number of provider receiving information**

Authorization is for the use and disclosure of the following records: **(please indicate information to be released)**

- ☐ **Surgery Record**

My authorization is given freely with the understanding that:

- **I may refuse to sign this authorization.**
- **I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.**
- **Great Lakes Surgery Center may not condition my treatment on my provision of this authorization.**
- **A photocopy or fax of this authorization is as valid as the original.**
- **Great Lakes Surgery Center, it's directors, officers, employees, agents, and volunteers are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.**
- **Upon my request, I will be given a copy of this signed authorization if the authorization is at the request of Great Lakes Surgery Center.**
- **This authorization is valid for one year or the following period of time:**

  _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Above

_____

If the above signed is not the patient, please indicate the relationship to the patient

- ☐ **Faxed**
- ☐ **Mailed**
- ☐ **Picked up**

Date: _____ **Emp.**

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