SURGICAL
ASSOCIATES
of marquette, pc
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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: ______________________________ DOB: ______________________________

Previous Name: ______________________________ SSN: ______________________________

I request and authorize: ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________________ State: __________ Zip Code: __________

Phone: ______________________________ Fax: ______________________________

Medical Information to be sent: (check all that apply)

_____ Entire medical record INCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to the treatment of HIV/AIDS.

_____ Entire medical record EXCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to the treatment of HIV/AIDS.

_____ Record of care from ________ to ________ INCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of HIV/AIDS.

_____ Record of care from ________ to ________ EXCLUDING information related to the treatment for substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of HIV/AIDS.

_____ Record pertaining to: ____

I authorize medical information to be released as indicated above. I understand this release is effective for one (1) year from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party.

____ ____________________

(Patient/Legal Representative) (Date Signed)

Revised ~~8/24/09~~, ~~4/29/10~~, ~~4/1/14~~, 2/11/15 wt