Surgery Center of Lakeland Hills Blvd
3340 Lakeland Hills Blvd
Lakeland, FL 33805
Ph 863-682-3239
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Authorization to Release Health Information

I, ____________________________, hereby authorize ____________________ (the "Center") to disclose health information regarding the following patient:

Patient Name: ________________________________ Date of Birth: ________________
Address: ________________________________ Patient's Phone: ________________
____

1. The information is to be disclosed to the following persons or organizations:
   Name: ____
   Address: ____
   ____

2. Purpose. The purpose of the use or disclosure is:
   ☐ At the request of the patient
   ☐ Other:
   ____
   ____

   If the purpose is for marketing, will the Center receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around ________________________ *(insert dates)*:

   ☐ The following medical records:

   - ☐ Discharge summary
   - ☐ Lab results
   - ☐ History and physical exam
   - ☐ Consultation reports
   - ☐ X-ray reports
   - ☐ HIV/AIDS test results and treatment
   - ☐ Alcohol and drug treatment records
   - ☐ Operative record
   - ☐ Progress notes
   - ☐ Photographs, videotapes, or other images
   - ☐ Mental or behavioral health records
   - ☐ Psychotherapy notes
   - ☐ Genetic test results
   - ☐ Entire medical record
   - ☐ Summary of treatment
   - ☐ Other (specify):

   ☐ The following billing and payment information:
   ____
   ____

   ☐ Other information:
   ____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Center will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.
☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of ______________________________.

Signed this _____ day of ___________, 200__.

Signature: ______________________________
Print name: ______________________________
Address: ______________________________
____
Phone No: ______________________________

Witness: ______________________________
Print Name: ______________________________
Date: ______________________________

(ONE COPY TO BE RETAINED BY THE REQUESTING PARTY)

For Office Use Only:
Date received: ____________________ Expiration date: ______________

How was identity verified? ________________________ Copy made? ☐ Yes ☐ No
How was authority verified?: ________________________ Copy made? ☐ Yes ☐ No

By: ______________________________ Title: ______________Date: ____________

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