From A.S.A

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Sarah Arnce, PA-C
Lacey M. Reed, PA-C
Rachel Sanders, PA-C
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: ________________________________

Patient Name: __________________________ DOB: ______/_____/______
Address: ____
City: ______________________ State: _____________ Zip: ______________________
Phone: _____________-_____________-_____________

Please Release the Following Information (check all that apply):

_______ History & Physical _______ Office Progress Note(s)
_______ Operative Report(s) _______ Labs: ____________________________
_______ Discharge Summary _______ Imaging: __________________________

Reason for Release of Medical Information:

- For Attorney Review
- For Other Medical Office Review
- For Personal Use / File
- Other: __________________________________

I authorize the release of records, including those which may contain CONFIDENTIAL HIV / AIDS RELATED INFORMATION, CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION, information relating to MENTAL HEALTH AND / OR ALCOHOL AND DRUG USE, from Advanced Surgical Associates, LTD.

I hereby authorize Advanced Surgical Associates, LTD, to release all of the above requested information relative to my treatment and care to:
Company / Person / Facility: ____
Address: ____
Phone: ________-_______-______________ Fax: ________-_______-______________

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has been taken. This consent will expire automatically six (6) months from the date on which it is signed. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purpose of the discloser.

____ Date: _______/______/_____________
***Patient's signature**
*If the patient is a minor and the information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent (or legal guardian) must sign.

____ Date: _______/______/_____________
Signature of Other Authorized Person
I affirm that the patient is deceased, that no personal representative of his/her estate has been appointed, and that I am the patients:

______________________________ ______________________________ Date: _______/______/_____________
Relationship **Signature**