SURGICAL ASSOCIATES of marquette, pc

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ DOB: _____

I request and authorize *Surgical Associates of Marquette, P.C.* to release and/or discuss healthcare information of the patient named above with the following individual(s):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

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

_____ Entire medical record *INCLUDING / EXCLUDING (Please Circle)* 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 / EXCLUDING (Please Circle)* 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.

Patient Information

We are legally obligated to protect your health information, patients may allow family members such as their spouse, parents, children or others to call and request medical or billing information. By signing this form we will only give information to persons indicated above.

I understand I have the right to revoke this authorization at any time. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

_____ _____

(Patient/Legal Representative) (Date Signed)