



PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Medical Record#: _____

DOB: _____ SSN: _____

Patient Address: _____

Dates of service requested for release: All Date Range: _____ to _____

Information to be disclosed:

- | | |
|---|--|
| <input type="checkbox"/> Office Visits | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> All of the Above |
| <input type="checkbox"/> Consultation Reports | |

1. I authorize the following health care provider to facility to **DISCLOSE** my patient information:

Name of Health Care Provider/Facility: _____
Address: _____
Phone#: _____ Fax#: _____

2. I authorize the following health care provider or facility to **RECEIVE** my patient information:

Name of Health Care Provider/Facility: Southern Surgical Associates, PA
Address: 2455 Emerald Place Greenville, NC 27834
Phone#: 252-758-2224 Fax#: 252-758-2860

3. I understand that this authorization included consent for the release of alcohol, drug, psychological information and any information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS and any AIDS related syndrome. It also includes any information concerning cancer, cancer testing, and cancer results. I understand that psychological reports will only be sent to another healthcare provider and not released to the patient.

4. Reason for Release: Legal Move Consult/Second opinion Personal

I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to the releasing provider.

I hereby and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which



are a part of my medical records. I agree that a copy of this release of a fax of this release shall be valid as the original release.

Signature of Patient or Representative

Date

Patient's Name

Name of Representative

Relationship to the Patient

Witness

OFFICE USE ONLY

Date Records Copied: _____

Copied by: _____

Medical Copies sent via: Mail Patient Pickup

Faxed to: _____