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# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _______________________________________________, ____________, hereby authorize
Name of Patient **(Print legibly)** Date of Birth

***Lakewalk Surgery Center*** to release medical information and/or copies of my health record (including, but not limited to that which involves treatment for alcohol/drug abuse or sickle cell anemia).

TO BE SENT TO: _________________________________

_________________________________

_________________________________

_________________________________

EXTENT OF INFORMATION TO BE SENT: (please be specific)

____ Including all dates of treatment
____ Between the date of ___________ and ___________

TO INCLUDE FINDINGS AND RESULTS OF:

____ Physician Notes

____ X-ray reports

____ X-ray films

____ Laboratory reports

____ Diagnostic test reports

____ Correspondence

____ Information required for the completion of submitted form

____ Other (specify) __________
______________________
______________________

I further stipulate that this authorization shall be void and of no effect one year after the date shown below and may be revoked in writing by me at any time except to the extent that action has been taken in reliance thereon.

__________________________________________
Signature of patient, parent of minor or
Legal guardian estate representative

__________________________________________
Witness signature required if patient
is unable to signs but uses X or mark

__________________________________________
Date of Signature

__________________________________________
Date of Signature

**ALL SECTIONS OF THIS AUTHORIZATION MUST BE COMPLETED FOR THE RELEASE OF MEDICAL INFORMATION**