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Lakewalk Surgery Center



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _____, _____, hereby authorize
Name of Patient 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	___ Correspondence
___ X-ray reports	___ Information required for the completion of submitted form
___ X-ray films	___ Other (specify) _____
___ Laboratory reports	_____
___ Diagnostic test reports	_____

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 sign 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**