LOVELAND SURGERY CENTER
3800 N. Grant Ave
Loveland, Co 80538
Main (970) 622-0608
Fax (970) 622-0610

Authorization to Release Medical Records/Information

From: _____ To: _____

Phone: _____ Phone: _____

Fax:_____ Fax:_____

Patient's Name: _____ Address:_____
DOB:_____ _____
Social Security #:_____ _____

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following conditions:

Initial: Initials
_____ Drug abuse if any _____ Substance abuse if any
_____ Psychological or psychiatric conditions if any _____ AIDS/HIV if any

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REASON FOR RELEASE OF RECORDS

_____ Specialist Referral
_____ Transfer of Care
_____ Legal
_____ Other _____

RECORDS RELEASED

____ Specified Date_____
____ All Records_____
____ Doctor's Note_____
_____Radiology Reports_____
_____ Laboratory Reports_____
_____ Other_____

_____Release only records generated by this facility (not including records received from other sources).

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time.
Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

I hereby authorize the use or disclosure of the health information described in this authorization. I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is re-disclosed by that recipient person or physician office.

Patient name (print): Person authorized to sign for patient (print)
_____ _____

Patient's signature Signature:
_____ _____
Relationship to patient: _____
Date:_____ Date:_____