LANCASTER SPECIALTY SURGERY CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient/ Previous Name | Birth Date | Medical Record Number

Street Address | Apt Number | City, State, Zip Code

AUTHORIZES: RELEASE OF PROTECTED HEALTH INFORMATION:

By signing this authorization form, I understand that I am giving my authorization to Lancaster Specialty Surgery Center to use and/ or disclose my protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):

TO: _____
Name of Health Care Provider/ Plan/ Other

_____
Street Address

_____
City, State, Zip Code

FROM: Lancaster Specialty Surgery Center
Name of Health Care Provider/ Plan/ Other

3056 Columbus- Lancaster Rd.
Street Address

Lancaster Ohio 43130
City, State, Zip Code

For the following date(s) of service: _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories.)

___ Further Medical Care
___ Insurance Eligibility
___ Legal Investigation or Action
___ Legal Investigation
___ Personal
___ Drug Testing
___Other (Specify): _____

INFORMATION TO BE RELEASED: ENTIRE RECORD _____, OR:

___ Exam, Operative Report
___ Treatment or Tests
___ Surgical Reports
___ Laboratory Reports
___ Xray Reports
___ Progress Notes
___ Anesthesia Records
___ Prescription(s)

I understand that if the person(s) and/ or organization(s) listed above are not health care providers, health plans or a healthcare clearing house, who must follow the federal privacy standards, the health information disclosed may no longer be protected by the federal privacy standards and my health information may be disclosed without obtaining my authorization. *You have a right to receive a copy of this authorization and you have the right to revoke this authorization. I understand that to have this request revoked I will need to provide a written notification to L.S.S.C.* **EXPIRATION DATE:** This authorization is good until the following date(s) _____ or until the following event occurs: I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ Date: _____

Signature of Patient/ Legal Representative

_____ Date: _____

Witness