Lutherville Surgicenter

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(PLEASE PRINT)

Patient Name:_____ Date of Birth: _____/_____ /_____

Patient Address: _____ SSN #: _____ -_____- _____

City:_____State:_____Zip Code:_____ Phone number: _____

I hereby authorize The Lutherville Surgicenter ("LSC") to release my Protected Health Information to: (Insert complete address)

Name:_____
(Physician, Attorney, Hospital, Agency, etc.)
Street Address:_____

City: _____ State: _____Zip Code:_____

Fax # (faxes will only be sent when 25 pages or less are copied) _____

Check Protected Health Information to be disclosed:

____DISCHARGE SUMMARY	___ OPERATIVE NOTES	____ PATHOLOGY REPORTS
____HISTORY & PHYSICAL	___ LABORATORY REPORTS	____ BILLING STATEMENTS
____PROGRESS NOTES	___ RADIOLOGY REPORTS	_____

I Do Not	I Do	Authorize release of information related to:
_____	_____	AIDS (Acquired Immunodeficiency Syndrome) or HIV {Human Immunodeficiency Virus) Infection
_____	_____	Alcohol and/or Drug Abuse
_____	_____	Sexually Transmitted Diseases

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP
_____LEGAL INVESTIGATION	_____DISABILITY DETERMINATION	_____PERSONAL

_____Other Please Describe _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Privacy Officer of LSC authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the Privacy Officer at LSC or request a copy of this authorization.

_____ _____
Signature of Patient or Authorized Representative Date

Fees for Copies: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies: if not, then copies will be mailed along with an invoice.