Sunset Ridge
SURGERY CENTER, LLC

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

****Please complete and return with a copy of your ID for verification****

PATIENT INFORMATION (Please print):

Name: _____ Date of Birth: _____ Last 4 of SSN: _____

Complete Address: _____

Telephone: _____

RELEASE RECORDS FROM:

Office Name: Sunset Ridge Surgery Center

Telephone: 702-445-6993 Fax: 702-445-7411

RELEASE RECORDS TO:

Office/Physician name: _____ Ph: _____ Fax: _____

---- or ----

Release them to me:

☐ Pick up

☐ Mail to my home address

☐ Email: _____

I authorize Sunset Ridge Surgery Center to use or release/disclose my health information as described below.

Please identify the information to be released:

Please release my **operative report** ☐ Please release my **pathology report** (if applicable)

---or---

☐ Please release ***only*** the following information: _____

The identified information will be used for the following purpose:

☐ My personal records

☐ Sharing with health care providers

☐ Other: _____

Please ***initial*** each item below to indicate your understanding.

_____ I understand the information in me health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____

Patient signature (or Signature of Person Completing Form if Not Patient) **Date**

*Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other

_____ _____

Witness Signature (SRSC) **Date**