



# LIGHTHOUSE SURGERY CENTER

Administrative Policies & Procedures

## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize the release of information from the medical record of:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Information Released to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

From:

Lighthouse Surgery Center

129 Woodland Street

Hartford, Connecticut 06105

Dates Requested:

From: \_\_\_\_\_

To: \_\_\_\_\_

Please check information to be released: (Reports may include information with history on drug/alcohol/psychological/HIV or communicable disease history.)

- Operative Reports
- Anesthesia Records
- PACU Records

- Laboratory Results
- Other Diagnostic Reports
- ALL

Purpose of Need for Disclosure:

- Personal Use
- Legal Purposes
- Insurance

- Continuing Medical Care
- Social Security/Disability
- Other:

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent is prohibited. I further understand I may revoke this consent (in writing) at any time except to the extent that action has already been taken.



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Lighthouse Surgery Center will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

Date Request Completed: \_\_\_\_\_

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Initials \_\_\_\_\_