AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

1. **I AUTHORIZE**:

Upper Bay Surgery Center
Name of Person or Organization

360 E. Pulaski Hwy
Street Address

Elkton, MD 21921
City, State, Zip

Phone Number: **410-620-3348**
Fax Number: **410-620-3351**

2. **TO RELEASE TO**:

_____
Name of Person or Organization

_____
Street Address

_____
City, State, Zip Code

Phone Number: _____

3. **INFORMATION TO BE RELEASED**: (*Check all applicable*)

- ❑ History and Physical
- ❑ Discharge Summary
- ❑ Operative Reports
- ❑ Pathology Reports
- ❑ Radiology Reports
- ❑ Laboratory Reports
- ❑ Progress Notes
- ❑ Nursing Notes
- ❑ Orders
- ❑ Consultations
- ❑ EKG
- ❑ Outpatient Surgery
- ❑ Entire Record
- ❑ Other:_____

4. **RECORDS FROM THE DATE(S)**: _____ /_____ /_____ ; _____ /_____ /_____

5. **THE PURPOSE OF THIS DISCLOSURE IS**:

- ❑ Continued Medical Care
- ❑ Personal
- ❑ Payment of Insurance Claim
- ❑ Worker's Compensation Claim
- ❑ Legal
- ❑ Other: _____

6. **DURATION OF AUTHORIZATION**: Unless otherwise revoked, this authorization is valid until _____ /_____ /_____, or for a period of one year, whichever is less.

_____
Patient's Name (at time of treatment)

_____
Street Address

_____
City, State, Zip Code

_____
Patient's or Representative's Signature

_____
Printed name of patient's representative (if applicable)

_____
Patient's Social Security Number

_____
Patient's Date of Birth

_____
Daytime Phone Number

_____
Date

_____
Basis of the representative's authority (if applicable)