



Pick-Up   
 Mail out

Account#  
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**Authorization for Release of Confidential Medical Records**

**I give Weston Outpatient Surgical Center permission to release the Medical records of patient:**

Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip Code \_\_\_\_\_

**To: (Leave blank if same as above)**

Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip Code \_\_\_\_\_

**For the purpose of:** \_\_\_\_\_

Which Dates of Service? \_\_\_\_\_

<input type="checkbox"/> All Medical Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Anesthesia Record	<input type="checkbox"/> Lab Report	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Billing Record	<input type="checkbox"/> Nurse's Notes	<input type="checkbox"/> Other
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report	
<input type="checkbox"/> ECG Report	<input type="checkbox"/> Pathology Report	

**I give permission for WOSC to release my health records as described above and I understand the following:**

1. If my record contains any highly confidential information such as HIV test, *and I want it released*, I must check the proper box (es) above.
2. To stop the release of this information I must write a letter to WOSC. The cancellation will not apply to information that has already been disclosed.
3. This Authorization will expire in 120 days unless I specify and earlier date.
4. The person/company that receives my information may re-disclose it and not have to obey Federal Privacy Laws.
5. WOSC cannot refuse to treat me for not signing this authorization.

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

\_\_\_\_\_  
 Date

Released by \_\_\_\_\_ On \_\_\_\_\_

\_\_\_\_\_  
 Authority to Act for Individual (WOSC Employee)

\_\_\_\_\_  
 Date

Initial to verify into Vision:  
 \_\_\_\_\_