rev11.11.10

AUTHORIZATION TO RELEASE INFORMATION

Please Complete and Mail or Fax - As Soon As Possible

Print Patient Name________________________________ Date____________________

To: ____
(Name of Institution Holding Records)

Address________________________ City________________ State_______ Zip______

I authorize you to release records to: Lansing Genesis Surgery Center, P.L.C.

Address 3400 E. Jolly Road City Lansing State MI Zip 48910

For the Purpose of:____
(Reason for Releasing Information)

Release the following portion(s) of Patient's medical record during the time period of
____.

Discharge Summary ❑	Physician's Orders ❑	ECG Report ❑
Nurse's Notes ❑	X-Ray Report ❑	Other ____________
Entire Medical Record ❑	Pathology Report ❑	________________
Lab Report ❑	Progress Notes ❑	________________
Operative Report ❑	History & Physical Report ❑	________________

This authorization will remain in effect for six months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by patient at any time, but it is not retroactive to release information made in good faith.

By signing this authorization, the undersigned agrees not to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent or authorization.

Proposed new use of information without additional written consent of the person to whom it pertains is prohibited.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that if there is a charge for copies, that such charges must be paid prior to release of copies.

________________________________ Signed____________________________
Signature of Witness (Patient/Responsible Party)

________________________________ Address____________________________
Patient's Birthdate City______________State______Zip______