Medical Records Release of Information

Patient name:____ Date of birth:_________________

Street: _________________________________ City:________________ State:_______ Zip:___________

I Authorize Rocky Mountain Surgical Center to release the following records (select all that apply):

- ☐ Operative Record
- ☐ EKG Report
- ☐ Lab Report
- ☐ Pathology Report
- ☐ Physician's Orders
- ☐ History & Physical Report
- ☐ Discharge Summary
- ☐ Nurses Notes
- ☐ Progress Note
- ☐ Entire Medical Record
- ☐ Other

To the following Person/Entity:

Name:____

Address: ____

Phone: ____________________________________ Fax:_______________________________________

Email:____

To the following reason:

____

____

____

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

This information is released in good faith for a specific reason No copies of released information may be disclosed to anyone without additional written consent of the person to whom it pertains, unless specified in this authorization. All information released will be stamped with a statement prohibiting re-disclosure.

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 there is a charge for copies and that such charges must be paid prior to the release of records.

Signature____Date_________