Authorization to Release Clinical Record Information

Print Patient Name:_____ DOB:_____

To: *Capital City Surgery Center*_____

(Institution Holding Records)

Address: *23 Sunnybrook Rd. Suite 100*_____

City: *Raleigh*_____ State: *North Carolina*_____ Zip: *27610*_____

I AUTHORIZE YOU TO RELEASE RECORDS TO:_____

Address:_____

City:_____ State:_____ Zip:_____

Email: _____ Phone: _____

Fax Number (If applicable):_____ Attn:_____

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	☐ Operative Record	☐ Anesthesia Paperwork
☐ EKG	☐ Physician's Orders	☐ Implant Log/Allograft
☐ Pathology Report	☐ X-Ray Image	☐ History and Physical

☐ Other: (Please specify documents requested: _____

☐ **ENTIRE MEDICAL RECORED**

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 the patient at any time, but it is NOT retroactive to release of 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 of authorization.

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

If patient is under 18 years of age:

Patient Signature: _____ Parent/Guardian Signature:_____

Date: _____ Relationship to Patient:_____ Date:_____

Witness: _____ Witness:_____