Pick-Up ☐ Account#

Mail out ☐ Chart#

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: _____

Date of Birth: _____ SSN# _____

Which Dates of Service? _____

☐All Medical Records	☐History & Physical	☐Physician Orders
☐ Anesthesia Record	☐Lab Report	☐Progress Notes
☐ Billing Record	☐Nurse's Notes	☐Other
☐ Discharge Summary	☐Operative Report	
☐ ECG Report	☐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.

_____ _____ Released by _____ On _____

Signature of Patient or Legal Representative Date

_____ _____ Initial to verify into Vision:

Authority to Act for Individual (WOSC Employee) Date _____