Sunrise Ambulatory Surgical Center

Request and Authorization to Release
Patient Medical Information

Patient Name:_____ Date of Birth:_____
Patient Address: _____ Social Security #: _____
_____

I hereby request and authorize the personnel at Sunrise Ambulatory Surgical Center, LLC ("Center") to disclose and release copies of the information specified below to the organization or individual(s) identified below. I understand that this release and authorization does not authorize the release of any information other than that information specifically described below.

I understand that the medical information described below contains identifiable health information realign to my diagnosis and treatment and consent to the disclosure and use of such information for the following purpose(s):_____

I understand that the information disclosed pursuant to this authorization could be re-disclosed by the recipient unless subject to further limitation under State law. I understand that I may refuse to sign this request and authorization and that my ability to receive treatment at the Center will not be affected by refusing to sign this request and authorization.

I understand that I may inspect, under supervision by Center personnel, or obtain a copy of, the health information that I am requesting release and disclosure. I understand that I may limit the disclosure of all or some of the information described below. I understand that I am entitled to a signed copy of this form.

Information to be released:
_____ Entire Medical Record
_____ Other: _____

Name and address of organization or individuals information is to be released to:

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____

I hereby certify that I am the [Patient, Legal Guardian or Representative of Patient] (circle one) and this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that this authorization is valid for one hundred eighty (180) days from the date that I sign it. I further understand that I may revoke this authorization at any time by providing written notice to the Center and that such revocation becomes effective upon receipt to the extent persons have already acted upon the request for release of information in reliance of this authorization.

_____	_____	_____
Patient or Legal Representative Signature	Print Name and Authority (if Legal Representative)	Date
_____	_____	_____
Witness or Interpreter Signature	Print Name	Date

In the event the patient is unable to be present at the Center to sign for the release of information, a notarized signature will be required.

State of _____
County of _____

On this _____ day of _____, 20____, before me personally appeared to me on the basis of satisfactory evidence to be the person whose name is subscribed to this document, and who acknowledged that he/she signed the above document.

_____
Notary Signature

(Seal)