

**AUTHORIZATION FOR RELEASE OF PROTECTED
HEALTH INFORMATION**

Patient Name _____

Date of Birth _____

The undersigned hereby authorizes the Bedford Ambulatory Surgical Center to release the following portions of the medical records of the above named patient to:

The information being released consists of (please check off):

_____ Complete Medical Chart _____ MRI films/disc

_____ Other _____

I understand that I may revoke this release at any time, in writing, but the request will remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first. EXCEPT to the extent that action has been taken thereon, I also understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS, or AIDS-related information may also be released.

Signature of Patient

Witness

Signature of parent, guardian or
Authorized Representative (state
Relationship)

Date