General Medical Records Release and
Authorization to Release Protected Health Information

Patient Name/MRN: ______________________________DOB________________

Primary Phone: ________________ Date(s) of service: ________________________

I, __________________________ (relationship to the patient) ____________________

Hereby authorize Northpointe Surgical Suites, LLC to release/disclose medical records to:

____

(Name of Person and/or Organization to which release is made)

For the purpose of: ____

Authorization is to release the following information:

- ☐ Abstract – medical information (History & Physical, Operative Report, Pathology Report [If applicable], Intra-Op Report, Anesthesia Record, Laboratory Results)
- ☐ Entire Medical Record
- ☐ Itemized statement
- ☐ Other (describe specifically) ________________________________

I, the undersigned, have read the above and authorize the staff of Northpointe Surgical Suites to disclose my medical information. I understand that this authorization is good for 180 days and may be withdrawn in writing by me at any time. A copy of facsimile of this authorization is as valid as the original. I acknowledge and hereby consent to such, that the released information may contain HIV testing, HIV results, or AIDS information. I also understand that released information may contain alcohol, drug abuse or mental status information or indication of such and that re-disclosure of this information to a party other than that designated is forbidden without additional written authorization on my part. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless, for complying with the "Authorization to Release Medical Records".

______________________________	______________________
Signature of patient (or patient's personal Representative)	Date
______________________________	______________________
Printed name of patient representative	Representative's authority to sign for patient, *(i.e. parent guardian, power of attorney for healthcare, executor)*

A copy of this signed authorization must be given to the individual.

3250 Northpointe Dr Zanesville, Ohio 43701 Tel: 740-487-1823 Fax: 740-487-1828