UFirstHealth™
No Mesh Hernia Surgical Center

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL RECORDS

Patient Name:_____ **DOB**:_____

I authorize the following provider, or entity to disclose certain protected health care Information pertaining to me:

Physician's Name:_____

Information to be released to:

Name:_____

Address:_____

Phone:_____ **Fax**:_____

Information to be disclosed:

◯ Complete Health Records
◯ Specific Dates of Service_____
◯ Specific Conditions_____

I understand that this WILL NOT Include the following Information unless Indicated and Initialed below.

_____Initials_____ Aids or HIV Infection
_____Initials_____ Behavioral Health Care/ Mental Health Services
_____Initials_____ Sexually Transmitted Disease Information
_____Initials_____ Treatment for Alcohol and/ or Drug Abuse

This Information Is to be disclosed for the purpose of_____

Are you leaving the practice? _____YES _____ NO

Reason for transfer of records _____

_____

I understand that this Release Is valid up to six (6) months from the date I sign It. When my Information Is used or disclosed pursuant to this Authorization, It may be subject to re-disclosure by the recipient and may no longer be protected under the Federal HIPAA Rule. I may revoke this Authorization at anytime, except to the extent that the practice has acted In reliance upon this Authorization. My revocation must be submitted in writing to the Site Supervisor, at the address listed above.

_____

Signature of Patient or Legal Representative **Date** **Relationship to Patient**

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