North Shore Surgi-Center Smithtown, NY 11787

Authorization to Obtain Health Information

(Doctor/Hospital/Facility:		
Address:		
City:	State:	Zip:

Patient Name: Last First Middle	Birthdate:	SS #:
Address:	City:	Zip:
Phone Number:		

I authorize you to disclose health information of the above named individual to:

North Shore Surgi-Center
989 West Jericho Turnpike, Smithtown, NY 11787

The type and amount of information to be used or disclosed is for current and future information created during my admission to North Shore Surgi-Center and is as follows: (include date where appropriate)
The type and amount of information created at North Shore Surgi-Center to be used or disclosed are as follows: (include date where appropriate)

- ☐ Operative Report
- ☐ Anesthesia Record
- ☐ Discharge Instructions
- ☐ Discharge Summary
- ☐ EKG
- ☐ History & Physical
- ☐ Laboratory Results
- ☐ Consultations Reports from _____to_____
- ☐ Medication Sheets
- ☐ Physicians Progress Notes from (date) _____to_____
- ☐ Physician Orders from _____to_____
- ☐ X-Rays, MRI from _____to _____
- ☐ Entire Medical Record
- ☐ Other: specify _____

Information is needed for: ☐ Personal Use ☐ Continuing Medical Care ☐ Legal Purposes ☐ Insurance ☐ Social Security/Disability ☐ Military ☐ Other, specify: _____

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. For AIDS and HIV status, the Department of Health Authorization must be completed instead of this authorization.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Medical Records.
Unless revoked, this authorization will expire on the following date, event or condition: _____
_____.
(You may indicate **"none",** if you do not wish to indicate a specific date.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed, as provided in applicable Federal and State Law. If I have questions about disclosure of my health information, I can contact the Medical Records Department.

Signature of Patient or Legal Representative:	Date:	Relationship to Patient
Signature of Witness:	Date:	