North Shore Surgi-Center
Smithtown, NY 11787

Patient Name: _____

Medical Record #: _____

Date(s) of Service: _____

Authorization to Release Health Information

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

I authorize North Shore Surgi-Center to use and disclose health information of the above named individual to:

(Doctor, Hospital, Attorney, Insurance Company, Self, Family Member)		Telephone Number:	
		Fax Number:	
Address:	City:	State:	Zip:

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: _____

Records of which NSSC's Program is authorized for release:

☐ Surgery ☐ Pain Management ☐ Sleep

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 general 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 the Medical Records Department. 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 Medical Records.

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

9/03