THE AMBULATORY SURGERY CENTER OF WESTCHESTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Patient Requesting Copies of Medical Record	
Street Address	
City, State, ZIP	
Date of Birth	Date of Surgery
Home Telephone	Work Telephone

I, the above named patient, hereby authorize The Ambulatory Surgery Center of Westchester to release the following information from my medical record(s):

Please list the specific information to be released:

To the individual listed below:

Name	Relationship To Patient
Street Address	
City, State, ZIP	
Home Telephone	Work Telephone

This release authorizes the disclosure of records for 30 days from the date of request. I understand that these records are protected under Federal and/or State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions.

I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Signature of Patient	Signature of Legal Guardian
Date	This authorization is valid for thirty (30) days from the date of signature.

For Office Use Only		
Medical Record information Released to:	[ ] Patient [ ] Individual listed above [ ] Other (please list):	
Fee: $0.75/page	Number of Pages copied	[ ] Credit Card [ ] Personal Check [ ] Cash
By:	Date	Fee Collected