Specialty Care
& Surgery Center

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) to release confidential medical information and records. Nore: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that apply and require specific authorization.

I hereby authorize: ❑ *SPECIALTY CARE & SURGERY CENTER* **OR**
❑ Other Physician or provider (please specify):

_____
Name

_____
Address

_____
City, State, Zip

To release my confidential health information by means of mail, fax or other electronic methods to: ❑ *SPECIALTY CARE & SURGERY CENTER* **OR**
❑ Other Physician or provider (please specify):

_____
Name

_____
Address

_____
City, State, Zip

The medical information will be used for the following purpose:

_____

This authorization is ❑ Unlimited ❑ Limited to the following medical information:

_____

This authorization shall be effective immediately and will remain in effect until _____ or for one year from the date of signature.
I have been advised of my right to receive a copy of this authorization.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Signature of Patient or legal/personal representative Date