Authorization to Release Health Care Information

UROLOGY

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ADVANCED LAPAROSCOPIC SURGERY

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A Division of Urologic Consultants, PLLC

Patient's name:_______________________________

Date of birth:____________

SSN:__________________

Previous Name: ______________________________

I request and authorize **Puyallup Ambulatory Surgery Center** to release health care information of the patient named above to:

Doctor:____

Puyallup Surgical Consultants
1519 3rd St. SE.
Puyallup, WA 98372

This request and authorization applies to:

_______ Health care information relating to the following treatments, condition or dates of treatment.____

_______ All health care information

_______ Other: ____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus). Sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

____

Signature of patient or patient's authorized representative Date signed

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Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Last Update 04/19/2010