PATIENT AUTHORIZATION FOR RELEASE OF SURGICAL RECORDS

Patient Information:
Full Name: _____
Date of Birth: _____
Social Security Number (Optional): _____
Phone Number: _____

To:
Hospital/Clinic Name: _____
Address: _____
City, State, Zip: _____

Records Requested:
I hereby authorize the release of my surgical records, specifically for the procedure performed on [Date of Surgery] regarding [Type of Surgery/Procedure].

The information to be released should include:
- Operative Reports
- Pre-operative Assessments
- Post-operative Reports
- Anesthesia Records
- Pathology/Lab Reports
- Discharge Summary

Please send the records to:
Recipient Name/Organization: _____
Address: _____
City, State, Zip: _____
Fax Number (if applicable): _____

Purpose of Disclosure:
[ ] Personal Use
[ ] Continued Medical Care
[ ] Legal Purposes
[ ] Insurance Claim

Authorization Expiration:
This authorization will expire on [Date] or 90 days from the date of signature if no date is provided.

Signature:

_____
Patient Signature (or Legal Representative)

Date: _____