Finesse Surgical Solutions

GENERAL • VASCULAR • COSMETIC

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Authorization for Release Of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Information needs to be released to: From:

_____ _____

_____ _____

_____ _____

Please release the following: *Initial each request*

_____ Complete Records _____ History & Physical _____ Hospital & ER Visit(s)

_____ Lab: _____ _____ X-Rays: _____ _____ EKG: _____

_____ Records from (Date) _____ to (Date) _____

_____ To allow Dr. Schlotter and/or staff to discuss medical care with the above named person(s).

_____ Please send most current doctor's notes and any recent test done pertaining to _____

_____

IMPORTANT: *Check all that needs to be excluded information (if applicable) pertaining to:*

_____ Mental Health _____ Drug/Alcohol _____ HIV/AIDS _____ Communicable Disease

Purpose or need for disclosure:

_____ Change primary care _____ Personal use _____ Attorney/legal

_____ PCP request copies _____ Insurance application _____Other (specify) _____

_____ Specialist care _____ Need family or friends to assist with medical care

HIPPA Federal Regulations

I understand the information released is the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified. I will not hold **Dr. Schlotter** liable for any misinterpretations of the information in my medical records as a result of not consulting my physician for the correct interpretation.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected. I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, for authorization of the release of testing results for pre-employment purposes.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____ _____

Relationship to Patient **Witness** **Expiration Date of Authorization**