ROCKFORD AMBULATORY SURGERY CENTER
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Last 4 digits of SSN: _____ Phone: ( ) _____

I hereby authorize Rockford Ambulatory Surgery Center ("RASC") to disclose the following Protected Health Information pertaining to the above-referenced patient to:
Person or Entity: _____

Address: _____ City/State/Zip: _____

Purpose of Release of Information: ☐ Personal ☐ Continuing Medical Care ☐ Other _____

Dates of Service: From: _____To: _____

INFORMATION BEING REQUESTED, PLEASE SPECIFY: (i.e., Records/Reports, Billing Records):
_____
_____

PLEASE NOTE:
If the above section is not completed, responses to this request will contain a record abstract of two (2) most recent years from the last date of service. This will include:

- History and Physical, Operative/Procedure Reports, & Pathology results

I understand this Authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Rockford Ambulatory Surgery Center will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this Authorization at any time except to the extent that Rockford Ambulatory Surgery Center has already taken action in reliance on it. I understand that in order to revoke this Authorization, I must do so in writing and present my written revocation to: Rockford Ambulatory Surgery Center, Attention: Privacy Officer.

I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information.

I understand that this Authorization will expire one (1) year from the date of signing unless specified below:

Desired Expiration Date: _____

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient (if not patient)