ROCKFORD AMBULATORY SURGERY CENTER AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:	Date of Birth:
Address:	City/State/Zip:
Last 4 digits of SSN:	Phone: ()
Information pertaining to the ab	mbulatory Surgery Center ("RASC") to disclose the following Protected Health pove-referenced patient to:
Address:	City/State/Zip:
Purpose of Release of Informat	ion: □ Personal □ Continuing Medical Care □ Other
Dates of Service: From:	To:
INFORMATION BEING REQ	UESTED, PLEASE SPECIFY: (i.e., Records/Reports, Billing Records):
years from the last date of servi • History and Physica	pleted, responses to this request will contain a record abstract of two (2) most recentice. This will include: 1, Operative/Procedure Reports, & Pathology results on covers records relating to communicable diseases, acquired immunodeficiency
syndrome ("AIDS"), human in	nmunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or tic testing, if any such records exist.
I understand that Rockford Authorization.	Ambulatory Surgery Center will not condition treatment on whether I sign this
Ambulatory Surgery Center ha	right to revoke this Authorization at any time except to the extent that Rockford as already taken action in reliance on it. I understand that in order to revoke this writing and present my written revocation to: Rockford Ambulatory Surgery Center.
I understand that the revocation Authorization.	on will not apply to information that has already been released in response to this
	mation is disclosed to a third party, the information may no longer be protected by may be redisclosed by the person or entity that receives the information.
I understand that this Authoriza	ation 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)