UnaSource
Surgery Center

4550 Investment Dr, Ste 100
Troy, MI 48098

AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: ___________________________________ Date of Birth: ____/____/____

I, ________________________, hereby authorize the UnaSource Surgery Center to release copies of, or obtain information from, the health records of the above named patient for the service date(s) ____/____/____ until ____/____/____.

The purpose of the release of this information is: (check all that apply)

☐ At the request of the individual above
☐ Other: ____

Specific information to be released: (check all that apply)

☐ Complete Medical Record

☐ Operative Report ☐ Pathology Reports
☐ Discharge Instructions ☐ Implant Log
☐ Anesthesia & Block Info ☐ Nurses' Notes
☐ Itemized Billing ☐ Other: _________________________

These copies or extracted information may be released to the following persons and/or organization:

Name or organization ____
Address ____
City ____________________ State ____________________ Zip _______________
Phone ___________________ Fax ____________________
Email ____

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to UnaSource Surgery Center. This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that to revoke this authorization, I must do so in writing. I understand that the information released may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws. Expiration date or event: _________________________.

Signature of Patient: _________________________________ Date: ____/____/____

If the patient is a minor or unable to sign, please complete the following:
☐ - Patient is a minor: ____ years of age ☐ - Patient is unable to sign because: ___________________________

Signature of Authorized Person: _________________________________ Date: ____/____/____

Print Name of Authorized Person: _________________________________

Authority of representative to sign on behalf of the patient:
☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ______________________

FOR UNASOURCE EMPLOYEE ONLY

MRN: EMAIL: