UnaSource Surgery Center
4550 Investment Dr, Ste 100
Troy, MI 48098

AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: _____ Date of Birth: _____

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

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
- ☐ Discharge Instructions
- ☐ Anesthesia & Block Information
- ☐ Pre-Operative Care Record
- ☐ Medication Reconciliation
- ☐ Pathology Reports
- ☐ Implant Log
- ☐ Medication Administration Log
- ☐ Post-Operative Care Record
- ☐ 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 _____

Preferred Method of Delivery: ☐ Encrypted Email ☐ Fax ☐ USPS ☐ Pick-Up

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: