# Surgical Associates of Ithaca

## Authorization to Release Information

Patient Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Telephone: _____

I authorize the release of the medical information regarding my care.

The following individual or organization is authorized to make the disclosure:

Name: _____ Telephone: _____

Address: _____

Please include:

| Records | Date(s) | Records | Dates(s) |
|---|---|---|---|
| □ Office/Consultation Notes | | □ Laboratory/Diagnostic Test Results | |
| □ Radiology Reports (Vascular,x-ray,MRI, CT, Ultrasound) | | □ Cardiology Reports(EKG, Stress Test, Cardiac Cath, etc. | |
| □ Operative Report | | □ Gastroenterology (Upper endoscopy, Colonoscopy, Manometry) | |
| □ Pathology Reports | | □ All my medical records | |

This information may be disclosed and used by the following individual or organization:

Name: _____ Telephone: _____

Address: _____

Reason for disclosure: ____My personal records ___Sharing with health care providers

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I may revoke this authorization in writing at any time. If I do it will not affect any previous actions already taken in reliance upon my authorization. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested to the Privacy Officer at the health care provider listed above.

_____ _____
Signature of Patient Date (This authorization expires in 90 days herof)

_____ _____
Parent or legal guardian (if Minor) Health Care Proxy or Power of Attorney