MEDICAL RECORD RELEASE

I, _____ hereby request that Big Sky Surgery Center release all the below indicated health
(Patient or Patients Representative Name)

care information, for _____, whether generated by Big Sky Surgery Center or any other source:
(Patient Name)

_____ **Verbal Discussion of Account/Medical Records**
_____ **Operative Report(s)** _____ **All Medical Records**
_____ **Lab/EKG/X-ray Report(s)** _____ **Other (Please specify):** _____

****Please note that billing records will not be produced unless specifically requested above…****
****Please check box ☐ if you do not want information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse and mental health conditions to be released.****

compiled during treatment date(s) from _____ until _____ to:

_____
(Name of person, attorney, healthcare provider or medical facility to whom records are to be released)

_____
(Mailing Address)

_____
(City) (State) (Zip)

_____ _____
(Phone #) (Fax #)

for the purpose of: _____

Revocation
This authorization is subject to revocation at any time by giving written notice to the Privacy Officer as indicated in the Big Sky Surgery Center (BSSC) Notice of Privacy Practices. The revocation is effective from the time it is received by BSSC and does not apply to actions taken prior to that.

Expiration
If not revoked, this authorization terminates thirty (30) months from the date of its execution, or on _____.

Acknowledgements
I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization as a condition of receiving treatment from Big Sky Surgery Center unless my treatment is research related or purpose of treatment is to generate information for a third party.

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse and mental health conditions. I give my specific authorization for these records to be released, unless designated above.

_____ _____ _____ - _____ - _____
(Patient Name - **Please Print)** (Patient Date of Birth) (Patient Social Security #)

_____ _____
(Signature of Patient or Patient's Representative) (Date)
****If you are signing as a Patient's Representative you must provide proof that you have been given the authority to do so.****