LEWES SURGERY CENTER

17015 OLD ORCHARD ROAD, UNIT 4
LEWES, DE 19958
Phone 302-644-3466 Fax 302-644-4001

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO THE PERSON OR ENTITY LISTED BELOW FOR USE AND DISCLOSURE

Patient Name: _____ Date of Birth: _____

I hereby authorize Lewes Surgery Center to release my individual identifiable Protected Health Information (PHI) to (list full name of requesting person & place of business):

_____

To use and disclosure for the specific purpose of (list what the requesting person and/or entity wants to use the PHI for):

_____

_____

I understand that my PHI may be redisclosed by the person or entity receiving my PHI from Lewes Surgery Center, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from Lewes Surgery Center. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

The following PHI is to be released:

Yes	No	Items Requested	Yes	No	Items Requested
❑	❑	Physician Notes	❑	❑	Drug/Alcohol Abuse
❑	❑	Lab Results	❑	❑	HIV Test results
❑	❑	X-Ray Reports	❑	❑	Mental Health Records
❑	❑	MRI Scans	❑	❑	LSC Claims/ Billing Information
❑	❑	CT Scans	❑	❑	Complete Record generated by LSC to include LSC Claims/ Billing information
❑	❑	EMG Reports			
❑	❑	Bone Scans	❑	❑	Complete Record generated by LSC **not** to include Claims/ Billing information

❑ Other: _____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying LSC in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Lewes Surgery Center in reliance on this authorization before Lewes Surgery Center receives my request for revocation or modification. I must sign and date my written request and send it to the following address:

Lewes Surgery Center
ATTN: Medical Records Department
17015 Old Orchard Road, Unit 4
Lewes, DE 19958

This authorization will expire on date: _____

Signature of patient or patient representative: _____ Date: _____

If you are signing as the patient's representative, print your name: _____

Relationship: _____