BARCLAY
Surgery Center

MEDICAL RECORDS RELEASE

RELEASE OF INFORMATION OF

Patient Name:	**Chart #:**	**Date:**
Name of Institution Holding Records:		
Address:		

AUTHORIZATION TO RELEASE RECORDS TO

Name of Person/Institution Requesting Records:
Address:

REASON FOR RELEASING INFORMATION

PORTION OF MEDICAL RECORD TO BE RELEASED

Date of Surgery/Service:					
Description		**Description**		**Description**	
Entire Medical Record		Physician's Orders		Nurse's Notes	
EKG Report		History & Physical Report		Progress Notes	
Lab Report		Discharge Summary		Procedure Record	
Pathology Report		Anesthesia Record		HIV/Aids Related Med Hx	
Other:					

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization is valid for six (6) months unless otherwise specified. It may be revoked in writing at any time but does not apply retroactively to information already released in good faith.

Information is released for a specific purpose and may not be further disclosed without additional written consent, unless specified in this authorization. All released records will include a statement prohibiting unauthorized re-disclosure.

By signing, I release the named institution from liability related to the release or examination of the specified records. I understand there may be fees for copies, which must be paid before records are released.

Signature of Patient / Rep:	Date:
Address:	Date of Birth:
Printed Name of Person Releasing Records:	
Signature:	Date: