CRATER LAKE
SURGERY CENTER, ASC

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I, _____, authorize
(Print Patient Name) (DOB)

□ Joseph Savino, M.D. □ George Johnston, D.O

to use and disclose a copy of the specific health information described below to:

_____
Name of Physician or Entity Phone: Fax:

The information to be disclosed is for the following purpose(s):

_____

By **initialing** the space(s) below, I specifically authorize the release of the following medical records, if such records exist:

_____ Clinician office chart notes
_____ Medical records needed for continuity of care
_____ Most recent two year history
_____ Emergency and urgent care records
_____ Other:

_____ Diagnostic imaging reports
_____ Laboratory reports
_____ Pathology reports
_____ Billing statements

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Genetic Testing Information
_____ Mental Health Information
_____ Drug/alcohol treatment or information

Transmission of records via fax is permissible: _____ (please initial)

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

This authorization may be revoked in writing at any time. Any use or disclosure already made with your permission cannot be undone. This authorization will expire 180 days from the date of the signature below.

I have read this authorization and I understand it.

_____
Patient or Representative Signature Date