



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

From: _____
 (hospital name)

 (city, state)

 (phone number of hospital, if known)

 (name of doctor who tied your tubes)

To: Lakeshore Surgical Center
 2320 Limestone Parkway
 Gainesville, GA 30501

I authorize this release of information to provide continuity to my medical care.

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for sixty days from the date of my signature below unless I specify an earlier expiration date in this space_____. I understand, also, that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved (see Notice of Privacy Practices).

It is my desire that only the information in my inpatient record or outpatient surgical record of tubal ligation / tubal surgery / cesarean section is to be released as a result of this authorization.
 (type of surgery performed)

I am also making the following additional qualification: IF the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be released in association with this authorization.

 (date) (patient signature) (witness)

To assist you, I am providing the following additional identifying information:

 (print name) (last name when your tubes were tied, if different)

_____/_____/_____
 (date of birth) _____ - _____ - _____
 (social security number) _____/_____
 (date your tubes were tied)

 (street address) (city) (state) (zip)

 (work phone) (home phone)