

**Cheshire Surgery Center**

765 West Johnson Ave. | Cheshire, CT 06410 | Phone: 860-378-8228 | Fax: 860-426-2558

**MEDICAL RECORD RELEASE AUTHORIZATION/REQUEST**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ MR#: \_\_\_\_\_

Current Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

**I authorize information to be sent to:**

\_\_\_\_\_  
Self, Physician, or Third Party Named

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Fax

**Purpose of Release (check one box):**

Referral/Consultation  Legal

Personal Use  Insurance

Other \_\_\_\_\_

**Indicate type of information to be released below:**

Operative Report  Laboratory Results requisitioned through SSC

Anesthesia Record  Other \_\_\_\_\_

For the following date/(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**The patient or the patient’s representative must read and initial the following statements:**

- a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. **Initials:** \_\_\_\_\_
- b. I understand that I may see and copy the information described on this form if I ask for it, and that Southington Surgery Center will give me a copy of this form after I sign it. **Initials:** \_\_\_\_\_
- c. I understand that this authorization will expire 30 days from the date I sign this form. **Initials:** \_\_\_\_\_
- d. I understand that I may revoke this authorization at any time by notifying Southington Surgery Center in writing, but if I do revoke it, the revocation will not have any effect on any actions Southington Surgery Center took before it received the revocation. **Initials:** \_\_\_\_\_
- e. I understand that once released, the record custodian, or its employees have no responsibilities or liability that may arise regarding any aspect of this authorization. **Initials:** \_\_\_\_\_

I understand that there may be charges associated with copying my medical record and assume responsibility for these fees.

\_\_\_\_\_  
Signature of Patient or Patient’s Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient’s Legal Representative

\_\_\_\_\_  
Relationship to Patient

**RETURN BY MAIL OR FAX:**

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765 West Johnson Ave.  
Cheshire, CT 06410

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