ADVANCED CENTER
FOR SURGERY

RELEASE OF INFORMATION CONSENT FORM

3280 Pleasant Valley Boulevard · Altoona. PA 16602 · Phone: (814) 381-0009, ext. 2005 · Fax: (814) 944-2836

Patient Name: ____ Date of Birth: ______________________

Surgery Date: __________________ Physician: _______________________________

Patient Address: ____

I hereby authorize: __________________________ to release the requested portion of my medical records to Advanced Center for Surgery.

RELEASE PURPOSE: ____

I understand that this consent may be revoked by me, in writing at any time, except to the extent that action has been taken in reliance upon it. I also acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Records Requested: (Check appropriate boxes)

- ☐ Office Visit Note
- ☐ X-ray Reports
- ☐ Operative Report
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Surgical Clearance
- ☐ All cardiac testing (EKG, stress, echo, halter monitor, cardiac cath)
- ☐ Other: Details:

DATES OF RECORDS REQUESTED (REQUIRED): ____

This authorization shall be valid for one year from date of signature.

Patient Signature: _________________________________ Date: __________________

If patient is unable to sign consent or is a minor, complete the following:

- ☐ Patient is a minor, years of age: ______
- ☐ Patient unable to sign: Reason: ______________________________

Relationship: ☐ Parent ☐ Legal Guardian ☐ Other: ______________________________