OVERLAKE SURGERY CENTER

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize Overlake Surgery Center to release my medical records to:

Name:_________________________________

Address:_______________________________

____

Phone Number:___________________________

I would like (check one):

____ All of my records released/requested

____ Only the following records released/requested

____

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- -

Patient's Name: (Please print)____

Birth Date:___________________________ SS#:____________________________________

I understand that my records my (or may not) contain information regarding the diagnosis or treatment of psychiatric disorders, alcoholism, drug dependency, sexually transmitted diseases, Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS), and that such information will be included with the records released in accordance with the above request. This authorization will expire 90 days from date signed below unless another date is entered here by OSC______________.

____

Signature Date

If signed by other than patient, please indicate relationship:_________________________________

FOR OFFICE USE ONLY: MRN#___________

1135 - 116TH Avenue NE, Suite 300 Bellevue, WA 98004

Phone (425) 709-2500 Fax (425)709-2323