LONE TREE
SURGERY CENTER, LLC

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

OBTAIN FROM:			RELEASE TO: (Receiving entity)		
Lone Tree Surgery Center, LLC					
Name			Name		
9218 Kimmer Dr, Suite 101					
Address			Address		
Lone Tree	CO	80124			
City	State	Zip	City	State	Zip
303-623-2680		303-623-2814			
Phone		Fax	Phone		Fax

INFORMATION TO BE PHOTOCOPIED AND RELEASED (CHECK ALL THAT APPLY):

Date of service range (month/year): From:_____ To:_____

____ Discharge Summary	_____ Radiology Images	_____ Other
____ Operative Report	_____ Nursing Documentation	_____ History and Physical
____ Provider Orders	_____ Laboratory Reports	_____ Anesthesia Documentation
____ Physician Orders	_____ Anesthesia Documentation	

THE PURPOSE FOR THIS RELEASE:

_____Continuity of Medical Care _____Damage/Claim Information _____Personal Use _____Legal

Other: _____

AUTHORIZATION: I hereby give Lone Tree Surgery Center, LLC. permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization. I acknowledge that incomplete forms can not be processed and **THAT THERE MAY BE A COST TO COPY THE RECORDS.**

I understand that **this consent expires 180 days from the date of my signature** unless otherwise specified as follows: _____ I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original.

_____ _____
Signature of Patient or Authorized Representative Date of Signature

_____ _____
Printed Name Relationship to Patient (if applicable)