TAYLOR STATION SURGICAL CENTER
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the RELEASE of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

Printed Patient's Name: _____

Patient's Birth Date: _____ Last 4 of Social Security Number: _____

I authorize (Please Check One):

☐ TSSC to **Send** patient records **To** (below): ☐ TSSC to **Receive** patient records **From** (below):

Name:_____

Phone:_____ Fax:_____

Address:_____ Suite/Apt #_____

City:_____ State:_____ Zip:_____

If you choose email, print email address below and choose secured or unsecured below:
Email Address: _____

☐ secured/encrypted email ☐ unsecured/unencrypted email*

*If you checked "unsecured/unencrypted email" please be aware there is some level of risk that your medical information could be read or otherwise accessed by a third party during transmission. By signing below, you have accepted this risk and still want your medical information sent by unencrypted email.

Information requested:

☐ Operative/Procedure Report(s) ☐ Lab/Testing Result(s)

☐ Pathology Report(s) ☐ Imaging

☐ Other (Specify)_____

For approximate date(s) of Service: From_____ To_____

For the purpose of:

_____ Further Medical Care _____ Legal Reasons
_____ Insurance Billing _____ Disability
_____ Self/Personal
_____ Other (Specify) _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment. I may inspect or copy any information used/disclosed under this authorization.

This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

Patient's Signature: _____ Date: _____

Guardian/Legal Representative Signature: _____ Date: _____

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. *This authorization will expire automatically 60 days from the date on which it is signed.* Cancellation of this authorization prior to the 60-day limit must be made in writing and sent to Taylor Station Surgical Center, 275 Taylor Station Road, Columbus, OH 43213.

Please contact (614)751-4475 regarding where to send this form.