Medical Record Release

Patient Information:

Name _____ Date of Birth _____
Address _____
Phone _____ Treatment dates _____ to _____
email _____

Covered Entity to release information:

Name _____ Phone _____
Address _____ F ax _____
email _____

Covered Entity to receive information:

Advanced Surgical Associates, PA
Address: 530 New Waverly Place, Ste 304
Cary, North Carolina 27518
Phone: (919) 851-9193 Fax: (919) 851-9223
Email: dkey@advancedsurgassociates.com

The patient has requested that the following Protected Health Information is to be released for treatment purposes:

- ☐ **Recent Photos/X-rays/Images**
- ☐ **Clinical/Progress Notes**
- ☐ **Labs**
- ☐ **Complete Record**
- ☐ **Other** _____

Patient Rights:

I understand that I have the right to refuse this authorization and that my treatment will not be conditioned on signing this document.
I understand that this authorization may be revoked at any time by giving written notice to the releasing covered entity. I understand that once my medical records have been released, the covered entity cannot revoke the information that has already been disclosed but no further releases will occur.
I understand that the information disclosed from this medical record release may be subject to redisclosure by the recipient for treatment, payment or operational purposes and the releasing covered entity has no control over the use and disclosure of the information.
I understand that this medical record release shall remain in effect until the information has been received by the requesting covered entity.

_____ Date_____
Signature of Patient or Legal Representative

_____
Print Name of Patient or Legal Representative

_____
Description of Legal Representative Authority (provide supporting documentation)

We at _Advanced Surgical Associates, PA_ use reasonable means to protect the security and confidentiality of emails sent and received, but we cannot guarantee the security and confidentiality of all email communications.