AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM the ASC

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Telephone: _____

PHOTO ID REQUIRED FOR RELEASE OF RECORDS

OBTAIN RECORDS FROM:	RELEASE RECORDS TO: (required)
Eye Center of Northern Colorado ASC 3151 Precision Drive Fort Collins, CO 80528 970-221-2222 Phone 970-221-2223 Fax	Name:_____ Address:_____ _____City: _____ State: _____ Zip Code: _____ Phone: _____ Fax: _____

The Eye Center of Northern Colorado Ambulatory Surgery Center provides the Operative Note as the record of the patient's procedure/surgery. Please specify in writing if you are requesting all ASC records below. Clinic records are not customarily provided with the ASC Records.
We will provide the most recent two years of records unless otherwise specified.

_____

_____

❑ I understand that my Clinic records may require an additional consent to obtain.

I hereby authorize the Eye Center of Northern Colorado, P.C. ASC to release the specified information as stated in this authorization. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health and drug or alcohol abuse. We will not include records from other doctors' offices. I hereby release the Eye Center of Northern Colorado, P.C. ASC and its employees from any and all liability that may arise from the release of information as I have directed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Without my express revocation, the authorization will automatically expire one year from the date of signature.

Patient Signature: _____ Date Signed:_____

Parent/Guardian Signature: _____ Date Signed: _____

❑ Patient/Guardian ID Verified ECNC ASC Staff Member Signature: _____

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