



Surgery Center of Northern Colorado, L.L.C.

3151 Precision Drive
Fort Collins, Co. 80528
Phone: (970) 221-2222 Fax: (970) 221-2223

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:
Eye Center of Northern Colorado ASC
3151 Precision Drive
Fort Collins, CO 80528
970-221-2222 Phone
970-221-2223 Fax

RELEASE RECORDS TO: (required):
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 ECNC 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: _____

Parent/Guardian Signature: _____ Date: _____

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