



Release of Health Information

I, _____, hereby authorize, _____, to disclose the following information from the health records of:

Patient Name: _____

Date of Birth: _____

Address: _____

Covering the period(s) of healthcare:

From: _____ to _____

The information to be disclosed:

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Inpatient Records	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Lab/X-ray Reports
<input type="checkbox"/> Progress Reports	

I understand that this will include information relating to (check if applicable):

AIDS (Acquired Immunodeficiency Syndrome or HIV (Human Immunodeficiency Virus))

Psychiatric Care

Treatment for Alcohol and/or Drug Abuse

This information is to be disclosed for the purpose of: _____

And is to be sent to:

Keystone Surgical Associates
826 Delaware Avenue
Bethlehem, PA 18015
Phone: 610-776-5025
Fax: 610-882-2018

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance upon this authorization. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Legal Guardian

Date