SPECIALTY SURGERY CENTER
SOUTH COAST

3420 Bristol St • Suite 750 • Costa Mesa • CA 92626
Tel.714.708.3737 • fax.714.708.3773

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: South Coast Specialty Surgery Center

Address: 3420 Bristol Street, Suite 750

City: Costa Mesa State: CA Zip Code: 92626

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: 7/20/2011

☐ All healthcare information

☐ Other: _____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Patient Signature: _____ Date Signed: 7-28-2011

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.