General and Colorectal Surgery
Rolando H. Saenz, MD

Authorization to Release Medical Records

I, ________________________________ (patient's full name), authorizes *San Lucas Surgical Associates* to release confidential health information about me to the individual(s) listed below:

1. Full Name: ______________________________________
   Relationship to Patient: __________________________DOB: _____ / _____ / __________
   Phone Number: (_____) _____-__________ Email (Optional): __________________________
2. Full Name: ______________________________________
   Relationship to Patient: __________________________DOB: _____ / _____ / __________
   Phone Number: (_____) _____-__________ Email (Optional): __________________________
3. Full Name: ______________________________________
   Relationship to Patient: __________________________DOB: _____ / _____ / __________
   Phone Number: (_____) _____-__________ Email (Optional): __________________________
4. Full Name: ______________________________________
   Relationship to Patient: __________________________DOB: _____ / _____ / __________
   Phone Number: (_____) _____-__________ Email (Optional): __________________________

I understand that the information released can include some or all of the following: a copy of my medical records, a summary or narrative of my protected health information, or a verbal conversation.
<u>Note</u>: While every attempt will be made to protect the privacy of your medical information, please note that release of your medical information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore is no longer protected by the Health Insurance Portability and Accountability Act (HIPPA) or other federal or state laws. This authorization will last in perpetuity unless you specify otherwise:

Special Notes or Requests by patient:

____

____

Full Legal Name of Patient (Please Print): ________________________________

Patient Date of Birth: _____ / _____ / ________

Patient SSN: ______-______-__________

Signature of Patient or Guardian: ________________________________

Date: _____ / _____ / __________

San Lucas Surgical Associates

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SAN LUCAS
SURGICAL ASSOCIATES

Medical Records Release Authorization

Patient name: ____Date of Birth: ____ / ____ / _______
Address: ____
Phone Number: (_____) _____-________ Treatment dates from: ____ / ____ / _____ to ____ / ____ / _____

I authorize: (enter your current provider's information)
Provider name: ____
Address: ____
Phone Number: (_____) _____-__________

To release copies of my medical records to:

❐ Rolando H. Saenz, MD

I understand that this information shall be in effect for one year following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the released copies.

I hereby release *San Lucas Surgical Associates* from any and all liability which may arise as a result of my authorized release of records. Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Signature of Patient or Guardian: **Date:**

_______________________________________ ____ / ____ / _________