Legacy Surgery Center

6918 Gunn Highway, Suite E. • Tampa, Florida 33625 • Phone 813-852-2500 • Fax 813-852-2541

RELEASE OF MEDICAL RECORDS AUTHORIZATION

In order to avoid any delay, this form must be completed in its entirety. Please print clearly.

Patient Name: _____ Maiden Name: _____

D.O.B. (Required) _____ Last Four # of SS (Required)_____

Home/Cell Phone: _____ Work: _____

Permission is hereby granted to Legacy Surgery Center to release medical information to the individual/Organization noted below or to have records released to Legacy Surgery Center:

Name: _____

Address: _____

City, State, Zip code: _____

Fax Number: _____

Name: _____

Address: _____

City, State, Zip code: _____

Fax Number: _____

Please check documents to be released:

O Medical Records **O** Office notes **O** Operative Report **O** X-ray/Photo **O** Billing Ledger

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner:

_____ Date: _____

Signature of patient /Legal Guardian

I understand I have the right to refuse this authorization in writing and Legacy Surgery Center is released from all legal liability that may arise from the released information requested.

_____ _____

Signature of patient /Legal Guardian Date