AUTHORIZATION TO DISCLOSE INFORMATION
Medical Record Release

Patient Name: _____
Last First Middle

Patient Address: _____

_____

Date of Birth: _____ Date of Service: _____

I, _____, hereby authorize Wilshire Surgery Center, LLC

to release to: _____

as required for the purpose of _____

The extent/nature of the information to be released should include:

_____

_____

_____

This authorization will expire 30 days from the date of signature below and I reserve the right to withdraw this authorization at any time.

_____ _____
Patient/Legal Guardian Signature Date of Signature

NOTE: If patient is unable to sign, individual signing must present information satisfactory to institution releasing information that individual is legally responsible for patient. Signature will be verified by personnel of authorized institution to release information.