NOVI
SURGERY CENTER

PLATINUM
ANESTHESIA & PAIN SERVICES PLC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: ______________________ Date of Birth: ____________

Previous Name: ______________________ Social Secrity #: ____________

I request and authorize ______________________________

to release healthcare information of the patient named above to:

Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: ________

This request and authorization applies to:

☐ Healthcare information related to the following treatment, condition, or dates: ________

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☐ All healthcare information

☐ Billing information

☐ Other: ______________________________

Patient Signature: ______________________ Date: ____________