LAKESHORE SURGICAL CENTER
Specializing In Tubal Ligation Reversal
Wm. Greene, Jr., M.D., FACOG
Wendell A. Turner, M.D., FACOG
2320 Limestone Parkway
Gainesville, GA 30501
Toll Free: (877) 588-5594
Fax: (770) 531-0053
www.PregnantAgain.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

From: _____
(Hospital Name)

_____
(City, State)

_____
(Phone Number of Hospital, If Known)

_____
(Name of Doctor That Tied Your Tubes)

To: Lakeshore Surgical Center
2320 Limestone Parkway
Gainesville, GA 30501

I authorize this release of information to provide continuity to my medical care. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for sixty days from the date of my signature below unless I specify an earlier expiration date in this space none . I understand, also, that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved (see Notice of Privacy Practices).

It is my desire that only the information in my inpatient record or outpatient surgical record of tubal ligation / tubal surgery / cesarean section is to be released as a result of this authorization.

I am also making the following additional qualification: IF the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be released in association with this authorization.

Patient Please Sign & Date Here!

_____ _____
(Patient Signature) (Date)

To assist you, I am providing the following additional identifying information:

_____ _____
(Print Name) (Last Name When Your Tubes Were Tied, If Different)

_____/_____/_____ _____-_____-_____ _____ / _____
(Date of Birth) (Social Security Number) (Date Your Tubes Were Tied)

_____
(Street Address)

_____
(City) (State) (Zip)

_____ _____
(Cell Phone) (Home Phone)

This form has been evaluated and determined to be HIPAA compliant.

LSC-005-05-2009