MNH Surgical Center

Information Release Consent

Date : _____ **Patient Name : _____**
(Name Sticker)

I authorize MNH Surgical Center to :

( ) Obtain information regarding my medical history , and lab results from my physician's office : _____
Dr.'s Name

( ) Release information regarding my procedure and diagnosis to my physician :

_____ , _____
Dr.'s name Dr.'s name

( ) Release information from my chart to the Hospital , in case there is a need for a transfer to that hospital , for follow-up medical care .

_____ _____
Signature of Patient or Legal Guardian Date of Signature

_____
Witness

Information regarding HIV Status , Drug & Substance Abuse , and Psychiatric Status is of extreme confidential nature , and will not be released .

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