Lake Grove Family Medical Clinic

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Phone Number:__(_____)_____

I authorize information to be released from:

Name of Facility:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone: _____ Fax: _____

Please send my records to:

Lake Grove Family Medical Clinic

Purpose of Release (Please check appropriate box):

☐ Changing Primary Care Physician
☐ Continuation of Care
☐ Other (Please Specify):_____

Type of information to be released:

☐ GENERAL medical records (Copies of medical records will be limited to two years of information including lab and imaging unless otherwise requested.)

☐ SPECIFIC information only:

- History & Physical (specify date)_____
- Medications/Therapy _____
- Lab, Pathology, EKG, X-ray (specify type) _____
- Operative Report (specify operation) _____
- Accident or Injury-Dates from_____ to_____
- Immunizations_____
- Other_____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. By **INITIALING** I authorize the release of the following protected or sensitive information.

_____Drug Abuse Diagnosis/Treatment
_____Alcoholism Diagnosis/Treatment
_____AIDS/HIV Test Results
_____Sexually Transmitted Diseases
_____Genetic testing
_____Mental Health Diagnosis/Treatment

Patient Authorization to Release Information
I understand that by signing I have the right to revoke this authorization at any time.

Signature of Patient or Legally Responsible Person:_____

Relationship to Patient:_____ **Date:** _____