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Lake Pediatrics

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SUITE 200
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MEDICAL RECORD RELEASE

I hereby authorize use or disclosure of the named individual's protected health information:

Patient Name: _____ DOB: _____

Social Security #: _____Telephone Number: _____

The following organization or individual is authorized to **release** requested information:

Name of Organization or
Individual to release information: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Information to be **sent to** the following organization or individual:

_____ LAKE PEDIATRICS @ ABOVE ADDRESS or:

_____ OTHER: Name of Organization or
Individual to receive information: _____

Address: _____

Telephone Number: _____ Fax Number: _____

INFORMATION TO BE DISCLOSED: (check all that apply)

Dates of Service(or range) _____

___Complete Medical Record ___Physician/Nurse Notes ___History & Physical ___Immunizations

___Laboratory Reports ___Microbiology ___Medications ___Consultations ___EEG Report

___MRI Report (_____) ___C-T Report (_____) ___X-Ray Report (_____)

____Other: (explain)_____
_____

May also disclose/release the following sensitive information:
___STD ___HIV/AIDS ___TB ___DRUG/ALCHOHOL ___MENTAL HEALTH ___ADD/ADHD

Re-disclosure: I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Right to Revoke: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Lake Pediatrics at the above address. I understand that the revocation will not apply to information already released based on this authorization.

Note: Revocation will not apply to insurance companies or branches of Medicare/Medicaid.

Other Rights: I understand that I may refuse to sign. Lake Pediatrics will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Expiration: Unless otherwise revoked, this authorization will expire in six months unless I specify an expiration date.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name Relationship to Patient

_____ _____
Witness Signature Witness Print Name

REVISED 07/2016