

LAKE HIGHLANDS MEDICAL PARTNERS

**Authorization to Release Medical Information
to Lake Highlands Medical Partners**

I, _____, hereby authorize
(Name of patient or legal representative)

(Name of person/entity who should release records)

(Address of person who should release records)

to release the following information by mail, fax, electronically or orally to:

Lake Highlands Medical Partners

8330 Abrams Rd., Suite 112

Dallas, Texas 75243

Office (214) 553-9009 Fax (214) 553-9003

From the health records of: _____
(Name of person whose record will be disclosed) (Social Security Number)

For the purpose of: _____

All records

Statements of charges or payments

Records of all visits

AIDS or HIV information

History and Physical Examination

Record of visit for a specific date(s).

Specific dates include or are limited to: _____

Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

Mental health and/or alcohol and drug abuse treatment

Other (must be specific): _____

Progress Notes

Discharge Summary

Consultation Reports

Hepatitis information

Photographs, videotapes, digital, or other images

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. **Lake Highlands Medical Partners**, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Patient's Printed Name

Date of Birth

Patient/Legal Representative Signature

Date

Relationship to Patient

Expiration Date of Authorization

Witness

Date