

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

I, \_\_\_\_\_, hereby authorize  
Lake Highlands Medical Partners. to disclose the following information by  
 mail  fax or  orally to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone or Fax Number: \_\_\_\_\_

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

For the purpose of: \_\_\_\_\_

My authorization extends only to those data elements/documents marked below:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>All records</b>                      | <input type="checkbox"/> Progress Notes                                    |
| <input type="checkbox"/> Statements of charges or payments       | <input type="checkbox"/> Discharge Summary                                 |
| <input type="checkbox"/> Records of all visits                   | <input type="checkbox"/> Consultation Reports                              |
| <input type="checkbox"/> AIDS or HIV information                 | <input type="checkbox"/> Hepatitis information                             |
| <input type="checkbox"/> History and Physical Examination        | <input type="checkbox"/> Photographs, videotapes, digital, or other images |
| <input type="checkbox"/> 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)
- \_\_\_\_\_

This authorization is given freely with the understanding that:

1. Any and all records, whether written or 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, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Medical Information Form to the clinic. The clinic will

act upon my revocation within two (2) working days of receipt. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.

4. Lake Highlands Medical Partners its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure 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.
7. The patient will be provided with a copy of this authorization.

_____	_____
Patient's Printed Name	Date of Birth
_____	_____
Patient/Legal Representative Signature	Date
_____	_____
Relationship to Patient	Expiration Date of Authorization
_____	_____
Witness	Date