LifeWay, Inc.

Medical Records Release Form

Date:________________________________

To:____

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By signing this form, I authorize you to release my protected health information and entire medical records to LifeWay, Inc.:

Secure Fax Transmission	Mail	Secure Electronic Messaging
(877) 632-8049 (Delivered directly into our Electronic Health Record)	**5333 N. Dixie Highway** **Suite 110** **Ft. Lauderdale, FL 33334**	**drlee@direct.MediTouchEHR.com** (*ONLY use if sent from an EHR with Secure Electronic Messaging)

I consent to the release of my complete medical record, including all documentation, test results and reports which may contain confidential health information relating to HIV/AIDS, mental health, and drugs and/or alcohol.

____
Patient's Name (please print)

____
Patient's Signature

____
Date of Birth

____
Date

5333 N. Dixie Highway, Suite 110
Ft. Lauderdale. FL 33334

Office: (954) 772-8554
Fax: (954) 772-9662
Email: info@LifeWayMD.com