TLC Medical Group, S.C.
PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM TLC MEDICAL GROUP

I authorize TLC Medical Group, S.C., to use or disclose the following information from the medical/health record of the person specified below.

1. **Patient Information**:

Name of Patient: _____ DOB: _____

Street Address: _____ City, State: _____ Zip Code: _____

Phone Number: _____

Are you leaving our practice?_____ Reason for leaving:_____

2. **Type of Patient health information to be disclosed:** (check all applicable boxes)

- The **entire medical record** (which may include highly confidential records such as Behavioral or Mental Health records, HIV/AIDS test results & records, Drug/Alcohol discussions & treatments, and Genetic Testing information & records).
- Medical records dated from _____to_____
- Only Behavioral/Mental Health records
- Only HIV/AIDS test results and records
- Only Drug/Alcohol related records
- Only Genetic Testing information and records
- Other (please specify)_____

3. **Expiration Date: This authorization expires on:_____**

4. **The information specified above will be disclosed to:**

Name: _____ Relationship to Patient: _____

Street Address: _____City, State:_____ Zip Code:_____

5. **This information will be disclosed for the purpose of:**

- At the request of the individual/guardian
- Continuation of care at another facility Name of facility: _____
- Permission to return to work, sick note, or medical excuse
- Insurance enrollment or claim processing Specify insurance company:_____
- Employment purposes
- Other: (please specify) _____

6. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization,. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
7. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is soley for the purpose of creating protected health information for disclosure to a third party..
8. I understand information used/disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by law.
9. I understand that this authorization is valid until the expiration date specified above, or if not specified, 1 year from the date of signature.
10. I understand that I may revoke this authorization at any time by giving written notice of my desire to do so, sent to the physician's office. I also understand that I will not be able to recvoke this authorization in cases where the physician has already relied on it to use or disclose my health information
11. I have read and understood the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowlingly and voluntarily authorize TLC Medical Group, SC to use or disclose my health information in the manner described above.

Printed Name of Parent/Legal Guardian: _____

Signature: _____ Date: _____

Printed Name of Patient if 12 years or older: _____

Signature: _____ Date: _____

Office Use Only: Fee/paid $_____/_____ Date called _____ Date mailed_____