Lakeside Internal Medicine, PLLC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____ Previous Name: _____

I request and authorize: _____
(Previous Healthcare Provider Name)

_____
(Healthcare Provider's Address/Phone/Fax)
to (release) or (obtain) my healthcare information (to) or (from):

Lakeside Internal Medicine, PLLC
10450 E. Riggs Road, Suite 110; Sun Lakes, AZ 85248

This request and authorization apply to:
[] Healthcare information relating to the following treatment, condition, or dates: _____

[] All Healthcare Information. **LAST 2 YEARS ONLY**
[] Other: _____

[] Yes [] No I authorize the release of my STD results. HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

[] Yes [] No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

****This authorization remains in effect for 1 year from date signed and may be revoked at any time by me (the patient) in writing to the medical record contact person at this site.**

Patient Signature: _____ Date **Signed:** _____

**** IF MORE THAN 15 PAGES, PLEASE MAIL RECORDS!!****