



LifeWay, Inc.

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Medical Records Release Form

Date: _____

To: _____

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

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Email: info@LifeWayMD.com