LAKEVIEW PLASTIC SURGERY

Alison Shore, MD

Patient Name: _____

Address: _____

Phone No.: (_____) _____

Date of Birth: _____

SSN: _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution:_____

Address: _____

City/State/ZIP: _____

TO: Person/Institution:_____
(Recipient)

Address: _____

City/State/ZIP: _____

Purpose or need for information: _____

Disclosure will include (*check all that apply)*

❑ Face Sheet ❑ History & Physical ❑ Laboratory Report ❑ Operative Report ❑ Other_____
❑ Discharge Summary ❑ Progress/Physician Notes ❑ X-ray/Radiology Report ❑ Pathology Report
❑ Emergency Report ❑ Nurses Notes ❑ EKG/EMG/EEG Report ❑ Consultation Report

Records for the period (dates) from _____ to _____

I understand that the information to be released may include: (*initial all that apply*)

_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment
_____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examinations, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at anytime in writing to the medical record contact person at this care site except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in 1 year after signing.** I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient

_____
Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug, alcohol abuse.