



Release of Medical Information Authorization

(Please Print)

-

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City/State/Zip: _____

Permission Is Hereby Given To: **Lakes Urgent Care**

2300 Haggerty Road, Suite 1010

West Bloomfield, MI 48323

to disclose information and/or copies of my medical records to:

Doctor/Facility Name: _____

Doctor/Facility Address: _____

Type of information to be released:

___ **All**; All related progress notes, dictation and reports for office, hospitalization and surgeries. Medication lists, testing results, x-ray reports and lab reports. Also included are records for treatment of physical and/or mental illness, chemical dependency and/or alcohol abuse or testing. Treatment of any communicable or infectious disease such as AIDS, HIV, ARC, VD, Tuberculosis, Hepatitis, etc.

___ **Other**: _____

This authorization will expire one hundred and twenty days (120) from the date signed unless otherwise specified.

Patient Signature (or Parent of a minor, or legal Guardian)

Date

Witness

Date

Your health information is kept confidential and is legally protected from disclosure by the Health Insurance Portability and Accountability Act.