LEW MEDICAL
DIPLOMATS OF THE AMERICAN BOARD OF FAMILY PRACTICE
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Medical Records

Patient's Full Name: _____ Date of Birth: _____

Patient's Address: _____ Phone Number: _____

I authorize the release of my medical records **from** the following facility:

Name of Facility: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

I authorize the above facility to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, and/or medical records by means of mail, fax or other electronic methods.

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Genetic information

[ ] Limited to the following medical information: _____

Authorization:

I hereby request that my medical records be released to: Lew Medical

_____ _____

Signature of patient or *legal/personal representative* Relationship *if other than patient*

It's the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPPA and California Law

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for 1 year from the date of signature if no date entered.