Requests will not be processed unless form is completed in its entirety.

LVIM
LAKELAND VOLUNTEERS IN MEDICINE

Patient Authorization for Release of Records

Lakeland Volunteers in Medicine
600 W Peachtree St. • Lakeland, FL 33815 • Phone: (863)688-5846 • Fax: (863)802-4640

RELEASE MEDICAL RECORDS FROM:

_____ Facility/Person

_____ Address, City, State, Zip

_____ Phone Number

_____ Fax Number

INFORMATION MAY BE DISCLOSED TO:

_____ Facility/Person

_____ Address, City, State, Zip

_____ Phone Number

_____ Fax Number

IDENTIFYING INFORMATION:

_____ Patient's Full Name

_____ Patient's Date of Birth

_____ Address

_____ City, State, Zip Code

_____ Patient's Phone Number

PURPOSE OF DISCLOSURE: *(select one of the following)*

☐ Continuity of Care ☐ Other: _____
☐ Patient's Request

Please check the following health information items to be released with a beginning date of _____ through _____.

☐ Office Visits ☐ Pathology Reports ☐ Immunizations ☐ Radiology Reports

☐ Other: (*List specific information*) _____

DELIVERY INSTRUCTIONS: *(select one of the following)*

☐ Mail to Patient ☐ Mail to Company ☐ Fax to Company

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, birth control and family planning, communicable diseases, hospice, or genetic test results. By Signing below, I specifically authorize the release of this information.

I understand this authorization will expire in **one year** from the date of signing unless otherwise specified _____.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulation.

I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid, or Medicare.

_____ Signature of Patient or Patient's Representative

_____ Date

_____ Name of Personal Representative (*if not patient*)

_____ Relationship *(if not patient)*