I authorize the following physician/facility to disclose information from my health record:

Physician Name _____ **Facility:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone Number: _____ **Fax Number:** _____

PATIENT IDENTIFICATION ***All information must be filled out completely to process your request***	_____ Patient Name _____ Address _____ _____ _____ City State Zip	_____ Date of Birth _____ Phone Number
	Dates of Service: From _____ To_____	
INFORMATION REQUESTED	❑ Office Visit Note(s) ❑ Laboratory Results ❑ EKG Report ❑ History & Physical ❑ Pathology Report ❑ X-Ray Reports ❑ Billing Record	❑ **Other:**
INFORMATION TO BE SENT TO	**MEDICAL RECORDS DEPARTMENT** Phone Fax:	

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that the practice will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The John C. Lincoln Physician Network Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I may receive a copy of this authorization.

Unless I revoke this authorization earlier, **it will expire one year from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release the practice, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient **or**
Description of Authority to Act for Patient

For Healthcare Use Only

Date Received: _____ **Date Sent:** _____ **Processor:** _____

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