LAKEWOOD
FAMILY HEALTH

Authorization and Request for Release of Medical Information

Patient Name: _____
Last 4 of SSN: _____
Date of Birth: _____

RELEASE RECORDS __ TO __ FROM
LWHP Family Wellness Group dba Lakewood Family Health
6331 Prospect Ave, Dallas, Texas 75214
Phone: (214) 821-6331 Fax: (214) 821-6332

RELEASE RECORDS __ TO __ FROM
_____
_____
_____

Request is made and permission is granted to release the following:

_____ Admission History and Physical
_____ Alcohol or Substance Abuse Records
_____ Discharge Summary
_____ EKG / Echo / Stress Results
_____ Entire Health Record
_____ Eye Exam Results
_____ Imaging Results
_____ Lab Results
_____ Mammogram Results
_____ Mental Health Records / Notes
_____ Office Visit Notes
_____ Operative / Procedure Reports
_____ Pathology / Biopsy Reports
_____ Treatment of AIDS or HIV records

Dates of service to include date from _____ to _____

The purpose of this request is for the following reason(s)
_____ At the request of the individual
_____ For continuity of medical management
_____ Transfer of care to another provider or leaving the area.

This authorization shall expire on the earlier of 6 months from the date signed, or on (Date) _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification LWHP Family Wellness Group or Lakewood Family Health attention Medical Release Correspondent, at the above address.

I hereby authorize LWHP or Lakewood Family Health to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name: _____
Patient Signature: _____ **Date:** _____
Phone: _____

Legal Representative: _____ Date: _____
Relationship: _____

Witnessed by: _____ Date: _____

Tara Cavazos, RN FNP-C, **Kendra Breithaupt, RN FNP-C** **Michelle Holcomb, RN FNP-C**