Lifetime Family Care, PLLC

Authorization To Release Medical Information

Patient Name: _____
Address: _____
Telephone: _____
Birthdate: _____

Released FROM: _____
_____
_____
_____

Released TO: **Lifetime Family Care, PLLC**
30229 Schoenherr Road, Suite 300
Warren, MI 48088
Phone: 586-751-1177
Fax: 586-751-1180

Specific type of information to be disclosed:

___Diagnostic Reports Only ___Laboratory Results Only ___Immunizations
___Chart Notes Only ___Consultations Only
___All Records Other_____

Dates: From: _____To: _____

This applies to all information in my medical records (including records relating to mental health care, communicable diseases, HIV and/or AIDS, and treatment of alcohol/drug abuse).

The purpose and need for disclosure:

___Transfer for Care ___Attorney Request ___Disability ___Workers'Comp
___Social Security ___Insurance
___Other_____

If necessary by requesting doctor, I authorize this information to be sent via FAX transmission.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I may revoke this authorization by notifying Lifetime Family Care, PLLC, in writing of my desire to revoke it. However, I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Without expressed written revocation, this consent expires after two years.

_____ _____
Signature of Patient Date Signed

_____ _____
Guardian's Signature/Legal Representative Relationship Date Signed