



Authorization to Release **MEDICAL RECORDS**

Patient Name: _____
 Other Name(s) Used: _____
 DOB: _____
 Phone: _____ Email: _____
 Address: _____
 City: _____ State: _____ Zip: _____

I hereby authorize **Lakeland Medical Associates** located at (Check One):

117 Medical Circle
 Athens, TX 75751
 Ph: (903)676-3200
 Fx: (833)428-4545
 Attn: _____

170 Municipal Drive
 GBC, TX 75156
 Ph: (903)887-7992
 Fx: (833)428-4546
 Attn: _____

(Check One)

to **OBTAIN** the selected medical records from: _____

to **SEND** the selected medical records to: _____

Person/Organization Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Email: _____

(Select all that apply)

All Records	Office Visit Notes	Phone Logs	Operative Notes
Hospital	Radiology Reports	Radiology Images	Lab/Pathology
Vaccines	Medications	Billing	Other: _____

(Initials Required to Release the following)

_____ Mental Health Records _____ Genetic Information/Test Results

_____ HIV/AIDS Testing/Treatment _____ Drug, Alcohol or Substance Abuse Records

This authorization is valid until the earlier of the occurrence of death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specified date(optional): Month ___ Day ___ Year _____. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization.

Today's Date: _____

Signature of Patient / Legal Representative: _____

Printed Name of Authorized Legal Representative: _____

If representative, specify relationship (circle one): Parent Guardian POA Other: _____