Lakeside Health & Wellness
Family Practice
1641 Creekside Dr, Ste 201 | Folsom, CA 95630
Phone: (916) 983-3069 | Fax: (916) 983-4569

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Purpose: This form is used to request an individual's conditioned authorization to disclose protected health information resulting from the provision of health care to the individual solely to create protected health information for a third party.

Patient: _____ Date of Birth: _____

I request and authorize Lakeside Health & Wellness
to receive my healthcare information from:

Name: _____

Address: _____

Phone: _____ Fax: _____

Protected Health Information to be Used and/or Disclosed:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition or dates:

_____

☐ Other:

_____

Purpose of this Authorization: Continued medical care

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be redisclosed by the recipient and may no longer be protected by federal HIPPA privacy law. I do not have to sign this authorization in order to receive treatment from Lakeside Health & Wellness.

Relationship to Patient: _____

Patient/Parent/Legal Guardian Signature: _____ Date: _____

You Are Entitled to a Copy of this Authorization After You Sign It

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED