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

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

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. This form may *not* be used to obtain authorization for use of disclosure of psychotherapy notes.

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: The specific protected health information we are asking you to authorize from the named party above to Lakeside Health & Wellness:

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

_____

☐ All healthcare information

☐ Other:

_____

Purpose of this Authorization: By signing this form, you will authorize the party named above to disclose the protected health information generated from that treatment to Lakeside Health & Wellness.

Effect of Declining this Authorization: This authorization is a condition of Lakeside Health & Wellness treating you. If you decide not to sign this authorization, we may decline to treat you.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Lakeside Health & Wellness. 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 also understand that, if I revoke this authorization, Lakeside Health & Wellness may stop treating me.

Signature – You May Refuse to Sign This Authorization:

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that you may disclose my protected health information to the third parties described in this form for the purposes stated in this form.

Personal Representative's Name and Relationship to Patient: _____

Patient's or Representative's Signature: _____ Date:_____

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

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED