Dr. Michael Lacey

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:________________________________ Account #: ______________________________________

I authorize: ___________________________ Address:____
(Company Name)

____

____

To release information from the medical record of: ____
(Patient's Full Name)

Reason For Request: ____

Please send records to:

____

____

____

ATTN: ____

For the purpose of review/examination, I authorize you to provide the following information:

- ☐ COMPLETED COPY OF MEDICAL RECORD
- ☐ DISCLOSURE LOG
- ☐ SPECIFIC INFORMATION

I give specific permission to release any information related to:

- ☐ SUBSTANCE ABUSE
- ☐ HIV/AIDS
- ☐ PSYCHIATRIC/MENTAL HEALTH INFORMATION

Identifying Information:

Name at time of treatment, if other than above: ____

Date of Treatment: ____

Date of Birth: _________________________________ SS#: ___________________________________

This authorization will expire sixty (60) days from the date signed. I understand that I make revoke this authorization, in writing, at any time except to the extent that an action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

Patient's or Legal Guardian's Signature ____

Relationship to Patient: ____

Witness: _______________________________________ Practice: ___________________________________