LISSA LUBINSKI MD

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Authorization to Release Medical Records

Patient Name: ______________________________________ Date of Birth: ___________________

Previous Name (if applicable): _____________________________________

Information to be released from:
Name (Facility or Provider): ____

Phone Number: ___________________________ Fax Number: ___________________________

Address: ____

Information to be sent to (via fax if at all possible):
Lissa Lubinski MD
816 E 8th St, Port Angeles, WA 98362
Phone: (360) 406-5220
Fax: (360) 775-2125

Information to be released:
__X__ The most recent 2 years of pertinent information (chart notes, labs, imaging, special tests, vaccines)
____ All medical records
__X__ Specific information (please specify): **Lab results, imaging, consultant notes**

Purpose for which the disclosure is being made:
__X__ Doctor/Medical/Continuity of Care
____ Insurance
____ Personal
____ Attorney

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
EXCLUDE the following information from the records released (please initial):
____ Drug/Alcohol abuse/treatment/diagnosis
____ HIV/AIDS diagnosis/treatment/testing
____ Sexually transmitted disease
____ Mental illness or psychiatric diagnosis/treatment

My rights
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing to the Practice. I understand that once this health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: ____ Date: _________________
(Patient, Guardian, or Authorized Individual)

This authorization expires 90 days from the date signed. Possible copying fee required.