LUIS LUGO M.D. INTERNAL MEDICINE PORTAL

REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize the use/disclosure of Health Information about me as described below.

Patient Name:_____

Patient D.O.B._____

Doctor/Organization Authorized to Provide Information:

Name:	Telephone
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____

_____ _____

Patient Signature Date

*NOTE

You have the right to know specifically what information you are authorizing for release (e.g. *results of a lab test performed on 1/4/13* or if your entire medical record is included, *all health information*) You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g. the names of your health care provider(s). You have the right to know who is going to use it and what it is going to be used for. (e.g. John Smith, PhD/ Research).

HIPPA Authorization for Release of Information