

**AUTHORIZATION FOR TOTEM LAKE FAMILY MEDICINE, PLLC TO
RELEASE HEALTH CARE INFORMATION**

Patient Name: _____ Date of Birth: _____

At my request please release my health care information from:

To:

Name / Organization: _____ Name/Organization: _____

Address: _____ Address: _____

City, State: _____ Zip: _____ City, State: _____ Zip: _____

Release the following information:

_____ Health care information, including lab and X-rays, relating to the following treatment or condition:

_____ Health care information for the date(s) below:

_____ *All health care information*

_____ Other: _____

For: Personal Reasons Other _____

I also agree to release the following information regarding testing, diagnosis, and/or treatment for *HIV (AIDS virus)*, *sexually transmitted diseases*, *Psychiatric disorders/mental health*, or *Drug and/or alcohol use*.

_____ This authorization is valid until I choose to cancel it.

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

- 1) Sign and date a revocation form. This form is available from Totem Lake Family Medicine, PLLC; or
- 2) Write, sign and date a letter to the Totem Lake Family Medicine, PLLC to cancel the authorization; or
- 3) Sign, date and write CANCEL on this original form.

Once the Totem Lake Family Medicine, PLLC gives out the information, we have no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I understand that signing this form is not a condition of my treatment at Totem Lake Family Medicine, PLLC

_____ Patient or legally authorized individual signature

_____ Date

_____ Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative etc

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