Lakewood Orthopaedics
Authorization to Release Medical Information
To Lakewood Orthopaedics

I, ____, hereby authorize
(Name of patient or legal representative)

____
(Name of person/entity who should release records)

____
(Address of person who should release records)

to release the following information by mail, fax, electronically or orally to:

Lakewood Orthopaedics
1130 Beachview Road, Suite 100
Dallas, TX 75230
Office (469) 341-5676 Fax (469) 341-5677

From the health records of: ____
(Name of person whose record will be disclosed) (Social Security Number)

For the purpose of: ____

All records
☐ Statements of charges or payments
☐ Records of all visits
☐ AIDS or HIV information
☐ History and Physical Examination
☐ Record of visit for a specific date(s).
Specific dates include or are limited to:_______________________________________
☐ Copies of records or reports provided to the above named (I.e. hospital, lab, clinic, ect.)
☐ Mental health and/or alcohol and drug abuse treatment
☐ Other (must be specific):____

☐ Progress Notes
☐Discharge Summary
☐Consultation Reports
☐Hepatitis information
☐Photographs, videotapes, digital, or other images

This authorization is given freely with the understanding that:

1. Any and all records, whether, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Lakewood Orthopaedics, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Patient's Printed Name	Date of Birth
Patient/Legal Representative Signature	Date
Relationship to Patient	Expiration Date of Authorization
Witness	Date