Lacamas Medical Group, PC
Family Practice, Urgent Care & Occupational Medicine

3240 NE 3rd Avenue Camas, WA 98607
Phone: 360-838-2440 Fax: 360-838-2450
www.lacamasmedicalgroup.com

# Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

Primary Phone Number: (  ) _____

| ☐ I authorize Lacamas Medical Group **to release information to:** | OR | ☐ I authorize Lacamas Medical Group **to obtain information from:** |
|---|---|---|
| Name of Facility (write self if releasing to yourself) | | Name of Facility |
| Providers' Name | | Providers' Name |
| Address | | Address |
| Phone/Fax *Include area codes | | Phone/Fax *Include area codes |

**PURPOSE OF REQUEST (Please check one):**

☐ Transfer of Care ☐ Specialty Care ☐ Insurance/Billing

☐ Personal ☐ Other (Please specify):_____

**TYPE OF RECORDS REQUESTED (Please check one):**

☐ All medical records in file ☐ Medical records from past two years ☐ X-Ray Films

☐ Immunizations ☐ Other (Please specify): _____

***Note:** You are hereby authorizing disclosure of information about HIV/AIDS status, drug/alcohol abuse, or STDs. Please initial here if you **DO NOT** want this information released: _____.*

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months from the date signed. . I understand that I may revoke this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made. I understand that I do not have to sign this authorization and that refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.

Signature of Patient or Representative:_____

Relationship to Patient (if not the patient): _____ Date: _____