Rochester Lifestyle Medicine Group

Medical Records Release Authorization

Patient Name: _____ Patient DOB: _____/_____/_____

For the purpose of coordination of care with my medical team, noted below, I authorize Rochester Lifestyle Medicine, PLLC to:

_____ Send copies of my medical record to:

1. Physician Name: _____ Phone: (____)_____

Physician Address:_____ Fax: (____)_____

_____

2. Physician Name: _____ Phone: (____)_____

Physician Address:_____ Fax: (____)_____

Authorization for Release of Health Information

I request that personal protected health information regarding my care and treatment be released as noted on this form. I understand the following:

1. I understand that signing this authorization is voluntary
2. I understand that I have the right to revoke this authorization at any time by writing to the health care provider noted above, except to the extent that such information has already been released.
3. I understand that this authorization does not authorize Rochester Lifestyle Medicine PLLC to discuss the disclosed personal protected health information with anyone other than the provider listed above.
4. I understand that Rochester Lifestyle Medicine, PLLC will only receive medical records that are relevant to my lifestyle evaluation, and will only send medical records regarding my lifestyle evaluation.

_____ _____

Signature Date