



AUTHORIZATION TO RELEASE MEDICAL/HEALTH CARE INFORMATION

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance provider(s), and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf.

DIRECTIONS: Please provide all family members or friends that are authorized to speak to us on your behalf. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do Not Release Information" option below.

RELEASE INFORMATION AS FOLLOWS:

I, _____, give the following named person(s) authorization to take
 (PRINT NAME ABOVE)
 messages or speak with the office of Dr. Alan M. Lazar on my behalf regarding:

(Please check all that apply.)

Appointments **Financial** **Medical Information** **Insurance**

Name of authorized person(s) _____ Relationship _____
 (PLEASE PRINT NAME)

Name of authorized person(s) _____ Relationship _____
 (PLEASE PRINT NAME)

Name of authorized person(s) _____ Relationship _____
 (PLEASE PRINT NAME)

DO NOT RELEASE ANY INFORMATION TO ANYONE

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV/AIDS, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use, I must specifically authorize the release of this information relating to such diagnosis, testing or treatment.

With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one ore more contacts listed above.

Patient Name: _____ Date: _____ / _____ / _____
 (PLEASE SIGN NAME)

Relationship or status if signed by anyone other than patient (parent, legal guardian, or personal representative)