Medical Information Release Form

LOTUS
PSYCHIATRY & WELLNESS

4545 42nd St NW, Suite 202
Washington, DC 20016
P: 240-428-4834 F: 888-488-5658

☐ I **DO** authorize Lotus Psychiatry & Wellness to do the following with my protected health information (please check all that apply):

__ Disclose/obtain protected healthcare information to/from individuals/entities listed below

__ Provide/receive a complete copy of my healthcare records to/from those individuals/entities listed below

__ Provide/receive only part of my healthcare records to those individuals/entities listed below
Information to be limited to: _____

Name/Entity: _____ Name/Entity: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

☐ I **DO NOT** authorize Lotus Psychiatry & Wellness to release any protected health information at this time. I understand that I may authorize the release of protected health information at any time by completing a new Medical Information Release Form.

I understand that any authorization I give on this form is valid for one year from the date signed, unless I revoke or withdraw this authorization through written communication to my provider at Lotus Psychiatry & Wellness or unless an earlier date is specified here: _____.

I understand that the medical information released may contain information sensitive information such as HIV/AIDS status, sexually transmitted diseases, mental health, and drug and alcohol abuse.

I understand that once my healthcare information is disclosed at my request, it may no longer be protected under federal and state privacy laws and could be re-disclosed by the person or entity receiving it.

I understand that there may be a fee for a copy or written treatment summary of my healthcare information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

_____ _____

Patient Signature Date

_____

Printed Name