Authorization for Release of Medical Records

I authorize **Mark B. Lindsay, M.D.** to release any information about my health and health care, including the diagnosis and treatment to:

Name: _____

Address: _____

_____

Phone: _____

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results and examinations. Any disclosure of my protected health information to a different name, class of person, or address will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance to this authorization. For the revocation of this authorization to be effective, the above name or class of person must receive the revocation in writing.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or Authorized Representative Signature:

X_____

Printed Name: _____

Previous last name if applicable: _____

Date of Birth: _____ Date: _____

For Office Use Only:

Office Representative: _____

Records Released/Sent Date: _____