Michael J. Lukowski, M.D.
6440 W. Newberry Rd. Ste. 201
Gainesville, FL 32605

MEDICAL RECORDS **RELEASE**

_____
Patient Number

Authorization for Use or Disclosure of Protected Health Information

Patient's Name: _____ Soc. Sec#: _____-_____-_____
Last First Middle

Telephone#: _____ Date of Birth: _____/_____/_____

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Send information to: (complete person's full name, organization or agency with full address):
RELEASE:
Name: _____

Attention: _____ Telephone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Purpose of exchange (ie: continued care, personal, etc.): _____

Specific items or dates needed: _____

Needed for doctor's appointment on: _____

This authorization is for **release/request** of medical records and information including diagnosis, treatment, and/or examination related to mental and /or physical health matters.

As required by state and federal law, Michael J. Lukowski, M.D. may not use or disclose your health information , except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of information disclosed to the persons/entities listed above without my further authorization.

I understand this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time and this must be done so in writing to the office of Michael J. Lukowski, M.D., 6440 W. Newberry Rd. Ste 201, Gainesville, FL 32605. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release Michael J. Lukowski, M.D. and his employees from any and all liability that may arise from the release of information as I have directed.

I understand that I may be charged a fee of up to $1.00/page (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical care. I understand that this fee is within the limits allowable by Florida law.

I hereby authorize Michael J. Lukowski, M.D. to **RELEASE** health information as described above.

Patient's Signature: _____Date: _____

Signature of Parent/Guardian: _____Date: _____

Relation to patient: _____

After completing this release, please return it to:
Michael J. Lukowski, 6440 W. Newberry Rd., Ste. 201, Gainesville, FL 32605
Or fax it to: (352) 332-3935, telephone number: (352) 333-0033.

Office Use Only

Pages Copied _____

Date: _____

Faxed by: _____

Faxed /Mailed

Other_____