LAFAYETTE
INTERNAL MEDICINE CLINIC

Telephone: (337) 504-3335 **Facsimile: (337) 504-4795**

MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

Name (if other than patient): _____ Relationship: _____ Phone # _____

□ Records are to be sent to *Lafayette Internal Medicine Clinic* from:

Physician's Office: _____

Physician's Specialty (if applicable): _____

Address: _____

Phone #: _____ Fax #: _____

□ Records are to be sent to:

Enter your name and address if you would like your medical records mailed to you*
Enter outside provider's information if you would like LIMC to send your medical records to another provider.

Name: _____

Physician's Specialty (if applicable): _____

Address: _____

Phone #: _____ Fax #: _____

Please Send the Following:

☐ All Records	☐ Radiology Reports	☐ Demo/Facesheet
☐ H&P	☐ Office Notes	☐ Insurance Info
☐ Lab Results	☐ Hospital Records	☐ Other: _____

☐ Please fax most recent progress notes & test results to: _____

Authorization: *I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I have read the above and authorize the disclosure of the protected health information as needed.*

_____ _____
Signature of Patient/Patient's Representative **Date**

_____ _____
Print Name of Patient's Representative **Relationship to Patient**

*When obtaining records from this office for personal reasons or permanent transfer there is a nominal copying fee. If it is necessary to obtain your records from storage, a flat rate of $25+ copying fees, will be charged