Longevity Wellness Group

Authorization for Release of Medical Information

Patient Full Name: _____ DOB: _____

Previous/Other Name: _____ (If different than patient listed above)

This will authorize (Physician's info):

Name: _____
Address:_____
City, State, Zip: _____
Phone, Fax: _____

To Release to:

Longevity Wellness Group
4101 Marathon Blvd
Austin, Texas 78759
Phone: 512-323-9222 Fax: **512-323-9232**

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- ☐ Complete medical records
- ☐ Lab reports
- ☐ Last 2 Progress notes, including medication list
- ☐ Immunization
- ☐ All Imaging
- ☐ Other _____

Reason for Release:

- ☐ To Update my regular doctor (provider)
- ☐ I have been referred to another doctor
- ☐ I want/need a second opinion
- ☐ I am changing doctor (provider)
- ☐ Dissatisfaction with care
- ☐ My insurance changed
- ☐ I am moving (New Address)
- ☐ Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION - PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes No

- ☐ ☐ Substance Abuse (alcohol/drug abuse)
- ☐ ☐ Mental Health/Depression (includes psychological testing)
- ☐ ☐ HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information.
Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.
RESTRICTIONS: The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

_____

Signature of patient or authorized representative: Witness: Date: