LifeTime Health Center
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Tyler, Texas 75701
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Authorization for Release of Medical Records

Patient Name_____DOB_____
Address_____
City_____State_____Zip_____
SSN_____

I hereby authorize LifeTimeHealthCenter to release or obtain medical records (confidential information) to/from:
Name of Doctor or Facility_____
Address_____
City_____State_____Zip_____
Phone#_____Fax#_____

Information to be sent or obtained:

- ☐All Records
- ☐Lab
- ☐Path
- ☐Radiology
- ☐EKG
- ☐Hospital Records
- ☐Progress Notes
- ☐Other

In keeping with our duty to protect our patient's confidentiality, this facility will not release any medical information without a signed Authorization for Release of Medical Records form. I understand that I may revoke this authorization in writing at any time prior to the information specified above being released. A parent or legal guardian will be required to sign the Authorization form if the patient is a minor or has been adjudicated incompetent to manage his or her own personal affairs, and an attorney has been appointed for the patient. This authorization does not expire.

Pursuant to state and federal law, you are hereby advised that the information you have authorized to release to/from LifeTime Health Center may include: test results, diagnosis, treatment for HIV (AIDs), sexually transmitted diseases, psychiatric disorders, drug and alcohol abuse. By signing this Authorization form, you release and hold harmless LifeTime Health Center and its employees from all legal responsibility or liability that may arise from the acts authorized above.

_____ _____
Signature of Patient or Legal Guardian Date