# *Lyn Lam, M.D.*

## *Gynecology/Urogynecology/Aesthetic Gynecology*

**Authorization to Release Medical Information**

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**Patient Name:** _____ **Date of Birth:** ____/____/____

**Address:** _____ **SSN#** ____ - ____ - ____

**City/State/Zip:** _____ **Phone#** (  ) ____ - _____

Please **OBTAIN** information **FROM** the following:

_____
**Name & Title of Provider/ Organization**

_____
**Street address**

_____
**City, State, Zip**

_____
**Phone** **Fax**

Please **SEND** my medical information **TO**:

**Lyn Lam, M.D.**

**65-1267 Kawaihae Rd.**
**Kamuela, HI 96743**
**Ph# 808-885-7511**
**Fax# 808-885-0933**

**For the purpose of:**

**[ ] Patient Care [ ] Insurance Claim [ ] Self [ ]Update PCP information.**
**[ ] Other:** _____ **[ ]Continued Care**

**Duration:**

This authorization shall begin immediately and remain in effect until (one) year after date shown below.

**AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS: (specify the type of records)**

**[ ] Any and All records [ ] Only records from _____ to present/**
**[ ] Records from _____date, to _____ date. [ ] Specific:_____**

***Requesting party assures that:**
***Request is submitted on behalf of a licensed health care provider, licensed in the state of (Indicate): _____**
***The information requested above is related to this provider's involvement in the patient's treatment or payment for that treatment.**
***SIGNATURE:**_____ **DATE:** _____
***PRINTED NAME:** _____ **TITLE:** _____

**The following (marked*) must be initialed by the requestor to be included in the use and/or disclosure of other health information:**

_____ *HIV/AIDS related information and/or records _____ * Mental Health Information
_____*Genetic Testing information _____** Drug /alcohol diagnostics, treatment, or referral information

**** Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.**

**Restrictions:** I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

**Rights**: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action on reliance upon this authorization.

**Signature:**_____ **Date:** _____ **Time:** _____