LUMIRI SURGICAL LLC
Dr. Tiffany Schatz
5550 Friendship Blvd. Ste 360
Chevy Chase, MD 20815
(240) 241-0420
Fax: (862) 298-0732

Authorization to Receive Medical Information

Patient Name (Type or Print):_____ Date of Birth:_____
Patient Phone: _____
RECEIVE RECORDS FROM:_____
Phone: _____ Fax: _____

Information to be released: (if not clearly defined, the most recent 2 years will be released)
History & Physical Date: ____/_____ (mm/yyyy)
Immunizations
Post Op Report Date: ____/_____ (mm/yyyy)
Most Recent: Lab X-Ray Office Visit Other Information
(Please specify) _____

Purpose for which disclosure is being made: (please check one of the following)
____ Attorney_____ Insurance _____ Doctor _____ Personal _____
Other _____

EXCLUDE the following information from the records released (please initial):
____ Drug/Alcohol abuse/Treatment and diagnosis _____ Sexually transmitted disease
____ Mental Illness or psychiatric diagnosis and treatment _____ HIV/AIDS

MY RIGHTS: I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by the HIPAA regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed with this authorization. There may be a charge for these copies. This authorization will automatically expire six months from the date signed or until the 3rd party payer claim is secured. I understand that I may revoke this authorization any time except to the extent that action has been taken in relationship thereon. To revoke this authorization, I must submit my request in writing to Lumiri Surgical LLC.

Signed: _____ Date: _____