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Medical Information Release Form (HIPAA Release Form)

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

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

PCP or Psychiatrist _____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____ If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

Signed: _____ Date: ____/____/____