LONGEVITY MEDICAL CLINIC™

Feel Younger · Live Better

AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: EMILY WAYMAN

Address: [redacted]

SSN: [redacted] Date of Birth: 06-18-55

I authorize Longevity Medical Clinic to disclose the above named patient's health information as described below, to the following recipient

Name of Clinic, Physician, or individual: Dr. Maidan

Address: _____

~~Phone~~: Fax (425) 899-9458

Reason: Labs Faxed to Cardiologist each time

Information to be released:

I understand that the information provided may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed.

REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Longevity Medical Clinic, at the address set forth above. The revocation will not apply to records and information that have already been provided.

EXPIRATION: This authorization will expire when the request has been filled.

PHOTOCOPIES OF THE AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize to use or disclose my health information in the manner describe above.

_____ _____

Patient / Legal Representative Signature Date