Michael D. Leu, D.Ph., N.D.

407 West A Street
Jenks, OK 74037
Ph: (918) 298-9300
Fax: (918) 298-9305
E-mail: info@drleu.com

Authorization to Release Lab Results without Consultation

I, _____ (Patient Name), _____ (Date of Birth) understand Dr. Leu has recommended a consultation to review my lab report. I understand that I am requesting a copy without his interpretation or recommendation to address any abnormalities. I authorize Michael D. Leu, D.Ph., N.D. to release my protected health information (PHI) to:

Individual or Company Name:	
Address:	
Phone:	
Fax:	

The following results are to be released:

	Lab Description	Sample Collection Date (Estimate if necessary)
1		
2		
3		

By signing below, I understand and agree that:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.
- I may be charged the legally permitted fee for sharing medical records

Patient or legal representative's signature: _____ Date: _____

Print Name: _____

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative): _____

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; three years after the signature date; or the following specific date (Optional): _____