Medical Release of Information Form

Name:_____ **Date of Birth: ___/___/___**

I authorize **Lux Infusion** to release my information, which includes but is not limited to demographics, diagnosis, medical records, medications, and anything else that is pertinent to my medical care. This information may be released to:

- ❑ **Any entity** that is directly related to my medical care at Lux Infusion (this includes other medical practices, hospitals, care homes, medical billing departments, insurance companies, pharmaceutical company patient care navigators or billing departments).

OR:

- ❑ Spouse: _____ Phone #: _____
- ❑ Child(ren): _____Phone #: _____
- ❑ Other: _____ Phone #: _____
- ❑ Other: _____ Phone #: _____

OR:

- ❑ Medical information is not to be released to anyone.

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

My Signature: _____ Today's Date: ___/___/___

If individual is a minor or unable to sign this ***Release of Information***, please complete the information below:

Name of Guardian: _____Legal Relationship: _____

Guardian Signature: _____ Today's Date: ___/___/___