MEDICAL RECORDS RELEASE

THIS MEDICAL RECORDS RELEASE (the "Release") is made _____ _____, _____.

TO: Client, _____
Phone: _____, Fax: _____ and all employees, contractors, and associated individuals thereof;

TAKE NOTICE THAT I, _____ (the "Patient"), do hereby request the following information be released:

Medical Records

1. All medical and health information except that pertaining to excluded subjects contained within:

a. Charts;

b. Notes;

c. Reports;

d. Records;

e.Medication lists, and other lists;

f. Prescriptions;

g. Flowcharts;

h. Emails;

i. Memorandum;

j. Orders;

k.Lab results;

l.Test results, and analyses;

m.Information related to treatment for mental health illnesses;

n.Diagnostic images and reports, including but not limited to X-Rays and EKG tracings;

o.Photographic images; and

p.Digital recordings, including but not limited to digital images.

q. Other: (Please list any concerns that you feel I should be made aware of that puts your life or health at risk (optional):

1.2 Information pertaining to the following subjects are excluded from this release:

a.sexually transmitted diseases or infections;

b.HIV or AIDS;

c.substance abuse; and

d.Anything Irrelevant That I DO NOT need to know, ONLY if it pertains to your safety during the tattoo process..

1.3 All information related to the accounting of the Patient's files, including but without limitation to Statements of Account.

1.4 All other authorizations previously received for the release of any or all of the Patient's medical information.

1.5 All of the above is collectively referred to as "Medical Records", as represented on paper, kept in folders, or stored digitally, electronically, or any other form.

1.6 "Medical Records" also includes production of any documents or material by physicians, nurses, chiropractors, dentists, therapists, counselors, consultants, technicians, and any and all staff of the organization to which this Release is directed.

Disclosure

2. I ask that the Patient's Medical Records be released to

Individual Name:	Augusto Cesar Lopez
Street Address:	Miami, FL, USA
Phone Number:	(645) 224-0577
Fax Number:	_____

2.2 I also ask that the Patient's Medical Records be released to me.

2.3 I am aware of the potential for information disclosed pursuant to this Release to be subject to redisclosure by me, or the recipient, and so may no longer be protected.

Time

3. I ask that the Patient's Medical Records be released within the next 30 days as required by the *Health Insurance Portability and Accountability Act.*

Notice and Additional Information

4. The contact information and particulars of the Patient are as follows:

Name:	_____
Date of Birth:	
Street Address:	_____
Phone Number:	_____
Email (optional):	_____

Duration of Medical Records Release

5. This Release will be valid until the earlier of when you receive written notice from me revoking this Release, or one month from its effective date.

Continuance of Ongoing or Future Care

6. This Release does not affect any ongoing or future care of the Patient.

SIGNED on _____ _____, _____ in the presence of:

_____ _____

WITNESS PATIENT