HealthLynked Medical Records Release Authorization Form

Patient Information:

First Name:

Last Name:

Date of Birth:

Address:

City:

State:

ZIP code:

Phone Number:

Email Address:

Authorization for Use or Disclosure of Protected Health Information (PHI)

Authorization:

I, the undersigned Patient, hereby authorize HealthLynked to collect my medical records and other healthcare information from various entities including but not limited to medical practices, hospitals, laboratories, and radiology centers. HealthLynked is entrusted to securely store my individual healthcare information, ensuring my direct control and access.

Effective Period:

This authorization for the release of information covers all past, present, and future periods of healthcare unless revoked as specified below.

Extent of Authorization:

I authorize the release of my complete health record, including but not limited to records of examinations, treatments, laboratory tests, and other medical information. This may include sensitive information relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

Use of Information:

This medical information may be used by HealthLynked for:

- My own purposes to share with my healthcare providers that I choose
- Medical treatment or consultation
- Other purposes as directed by me

Transmission of Records:

Please transmit my medical records to HealthLynked Patient Medical Record Service using any available means:

Fax Number: 1-866-542-1082

Phone Number: 1-800-928-7144

Email: support@healthlynked.com

Website: www.HealthLynked.com

Address: 1265 Creekside Pkwy, Suite 302, Naples, FL 34108

Labs or Radiology Centers to Collect Records From:

(We recommend check both Quest and LabCorp)

☐ Quest Diagnostics

☐ LabCorp

Additional Labs or Radiology Centers:

Facility Name:

Address:

City:

State:

ZIP code:

Phone Number:

Fax Number:

Email Address:

Doctors and Practices to Collect Records From:

Request 1:

Practice Name:

Doctor/ Provider Name:

Address:

City:

State:

ZIP code:

Phone Number:

Fax Number:

Email Address:

Request 2:

Practice Name:

Doctor/ Provider Name:

Address:

City:

State:

ZIP code:

Phone Number:

Fax Number:

Email Address:

Request 3:

Practice Name:

Doctor/ Provider Name:

Address:

City:

State:

ZIP code:

Phone Number:

Fax Number:

Email Address:

Revocation Rights:

I understand that I have the right to revoke this authorization in writing at any time. The revocation will not affect any actions taken before the receipt of the revocation. To revoke this authorization, I must contact HealthLynked at the address provided above.

Patient Signature/Guardian Signature:

Date: