

# Lemire Clinic

JAMES E. LEMIRE, MD, PA  
Natural family medicine with a personal touch  
*Request for Medical Records*

## Records Requested From:

\_\_\_\_\_  
Physician / Physician Group / Medical Facility

\_\_\_\_\_  
Fax number

\_\_\_\_\_  
Telephone number

I hereby authorize \_\_\_\_\_ to release copies of the medical records  
of \_\_\_\_\_ to Lemire Clinic, James E. Lemire, MD, P.A. for the specific purpose  
of:  Continuing Medical Care  Other \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

of:  Continuing Medical Care  Other \_\_\_\_\_

This request is for the complete medical record, including: (initial each line that applies)

\_\_\_\_\_ Psychiatric / Mental Illness

\_\_\_\_\_ Drug and / or alcohol abuse

\_\_\_\_\_ HIV Testing

\_\_\_\_\_ ARC and / or AIDS

I understand that this consent is valid for one (1) year and is revocable upon written notice to your office, except to the extent that action has already been taken on this authorization. Alcohol, drug, HIV, ARC and / or AIDS information, if present in the record, will be disclosed only if authorized above.

I further understand that I may select which information from the above list of confidential information will be released, by placing my initials in the area provided. I acknowledge that I have read this authorization, fully understand its contents, and have voluntarily signed it on this date.

**A COPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL**

\_\_\_\_\_  
Signature of Patient / Parent / Guardian / Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Soc. Sec. Number

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Please send the medical records information to:

Lemire Clinic  
9401 SW Hwy 200 Bldg. 90  
Ocala, Fl. 34481-9612

Phone (352) 291-9459  
Fax (352) 291-9465

### NOTE:

**ANYTHING OVER  
10 PAGES PLEASE  
MAIL.**

**PROHIBITION ON REDISCLOSURE - THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY LAW. ANY FURTHER DISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATIENT PROVIDES SPECIFIC WRITTEN CONSENT FOR SUBSEQUENT DISCLOSURE OF THIS INFORMATION. THESE RECORDS MAY BE PROTECTED BY FEDERAL REGULATION (42 CFR, PART 2). FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ALCOHOL / DRUG ABUSE.**