May 12th, 2021

RE: *LAGS Medical Centers Permanent Closure*

To Our Valued Patients,

We would like to thank you for the trust you have given us as your Pain Management providers. Our top priority is the health and well-being of our patients, families, staff and community. In this unprecedented time, we are deeply committed to keeping everyone safe.

Please be advised that due to unforeseen circumstances Lags Medical Centers will be closing effective May 19th, 2021.

Please contact your primary care physician and your health plan as soon as possible to ensure a smooth transition of care. When allowed by your health plan, a LAGS provider will be reviewing your medical notes and if appropriate a medication refill will be sent for up to 30 days.

For medical records request please contact 888-712-0015 or fax your request to 855-574-2244 or send an email to medicalrecordsrequest@lagsspine.com

Sincerely,

Francis P. Lagattuta, M.D.
Medical Director
Lags Spine and Sportscare Medical Centers, Inc.

[Enclosure]

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	Name:______________ DOB:______________ Address:______________ Phone: ______________ City: ______________ State:______________ Zip:______________
(Clinic/Hospital/Health Care Provider) *Where are the records from?*	Physician/Person/Facility Name:______________ Address:______________ Phone: (_____)______ City: ______________ State:_______ Zip:_________Fax ( )______________
(In House Clinic) *(Where do the records go to?*	STAMP HERE Location: ______________ Fax: ______________ Phone Number:______________
Information to be Released *(What do you want sent?)*	**Record Types Only:** ☐ Radiology Reports ☐ Progress Notes ☐ Operative Reports ☐ Billing Records ☐ Lab Reports ☐ Medication Record ☐ Other ______________ **Date Range for Release:** Start Date:______________ End Date:______________
Purpose of Release	*Reason for the release of information*:______________

DISCLOSURE

I authorize the use and disclosure of my health information as instructed above. I understand that if the person or organization I authorize to receive the information is not my provider or my health plan, the information is no longer protected by federal regulations and could be re-disclosed. I also understand that I may revoke this authorization at any given time unless it has been acted upon with reliance. Your signature indicates that you read and understand this form, therefore you authorize LAGS Medical Centers providers to use or disclose the information as instructed above.

THE RELEASE OF MEDICAL RECORDS TAKES 7-10 BUSINESS DAYS. I UNDERSTAND THERE MAY BE A CHARGE FOR MULTIPLE COPIES OF MY RECORDS.

______________ Patient Name | ______________ Patient's Rep Name | ______________ Date

______________ Patient's Signature | ______________ Patient Rep Signature | ______________ Date