LAWRENCE MEMORIAL HOSPITAL / LMH PHYSICIANS CLINICS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Lawrence Memorial Hospital is required to obtain your authorization for any use or disclosure of your protected health care information (PHI) for purposes other than treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices before signing this authorization.

PATIENT NAME ______________________________________**DOB**________________**SSN**_____________________________

PHI – RELEASE FROM:	**PHI - RELEASE TO:**
____ **Name** ____ **Fax** ____ **Phone** ____	**Lawrence Memorial Hospital** **Emergency Department** **Fax: (785) 505 - 5206** **Phone: (785) 505 - 6162**
PURPOSE OF DISCLOSURE: ____	**EXPIRATION DATE OF AUTHORIZATION:** _________________________________ **If not noted – this authorization will expire 90 days from the date it was signed.**

REPORT	**VISIT DATE(S)**	**REPORT**	**VISIT DATE(S)**
☐ Final Case Summary	__________________________	☐ Radiology/Imaging	________________________
☐ History & Physical	__________________________	☐ Emergency Dept.	________________________
☐ Consultation	__________________________	☐ Other (List)	________________________
☐ Operative/Procedure	__________________________	☐ Physician Office (specify)	________________________
☐ Lab/Pathology	__________________________	☐ ____________________	________________________

YES		**NO**	
________	**DRUG & ALCOHOL PHI**	________	**You must <u>initial</u> in the appropriate space that applies to authorization for disclosure of this specific protected health care information. For disclosure of mental health, psychotherapy PHI, see reverse side of this form.**
________	**HIV/AIDS PHI**	________	
________	**GENETIC TESTING**	________	

<u>You may:</u>

- **Request to inspect or copy the information that LMH intends to disclose.**
- **Refuse to sign this Authorization.**
- **Revoke this Authorization in writing at any time, by delivering a written revocation to the Director of Health Information Management Services, Lawrence Memorial Hospital, or his/her designee, except to the extent that LMH has already released information in reliance on this Authorization.**

<u>LMH may:</u>

- **NOT require that you sign this Authorization to receive treatment.**
- **Assess appropriate and reasonable fees for the copying of such information. Such fees will comply with federal and state laws.**

I have read the above information and authorize Lawrence Memorial Hospital to disclose the identified information to the person(s) and for purpose described herein. I understand that, by signing this document, I release and discharge Lawrence Memorial Hospital from any and all liability and will hold Lawrence Memorial Hospital harmless for any release made pursuant to this Authorization. I understand that if the person or entity that receives the described information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

____ ______________ ____

Signature of Patient, Guardian or authorized representative Date Relationship

_________________________________ _____________ _____________________________ ___________

Witness Date Witness Date

Disclosure of PHI to LMH ED
8120-0480 adm21
O: Rev 7/2016

Patient Label

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION MENTAL HEALTH, PSYCHOTHERAPY NOTES

Lawrence Memorial Hospital is required to obtain your authorization for any use or disclosure of your protected health care information (PHI) for purposes other than treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices before signing this authorization.

PATIENT NAME ______________________________________**DOB**________________**SSN**_____________________________

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____ **Name** ____ **Fax** ____ **Phone** ____	**Lawrence Memorial Hospital** **Emergency Department** **Fax: (785) 505 - 5206** **Phone: (785) 505 - 6162**
PURPOSE OF DISCLOSURE: ____	**EXPIRATION DATE OF AUTHORIZATION:** ________________________________ **If not noted – this authorization will expire 90 days from the date it was signed.**

REPORT	**VISIT DATE(S)**
☐ Mental Health/Psychotherapy Notes	__________________________

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____ _____________ ____
Signature of Patient, Guardian or authorized representative Date Relationship

____________________________________ _____________ __________________________________ __________________
Witness Date Witness Date

Patient Label