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:**
Lawrence Memorial Hospital **Health Information Management** **325 Maine** **Lawrence, KS 66044** **785-505-3093**	**Name**_____ **Address**_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____
PURPOSE OF DISCLOSURE: _____	**EXPIRATION DATE OF AUTHORIZATION:** _____ **If not noted – this authorization with 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**	_____
_____	**HIV/AIDS PHI**	_____
_____	**GENETIC TESTING**	_____
_____	**SENSITIVE DOCUMENTS**	_____

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 see reverse side of this form.

<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

Auth for Use/Discl of PHI
8120-0328 adm11
REV: 4/14/2017

LAWRENCE MEMORIAL HOSPITAL

Patient Label

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION MENTAL HEALTH

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:**
Lawrence Memorial Hospital **Health Information Management** **325 Maine** **Lawrence, KS 66044** **785-505-3093**	**Name**_____ **Address**_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____
PURPOSE OF DISCLOSURE: _____	**EXPIRATION DATE OF AUTHORIZATION:** _____ **If not noted – this authorization with expire 90 days from the date it was signed.**

REPORT	**VISIT DATE(S)**
☐ Mental Health	_____

YES		**NO**	
_____	**DRUG & ALCOHOL PHI**	_____	**You must initial in the appropriate space that applies to authorization for disclosure of this specific protected health care information.**
_____	**HIV/AIDS PHI**	_____	
_____	**GENETIC TESTING**	_____	
_____	**SENSITIVE DOCUMENTS**	_____	

You may:

- 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.

LMH may:

- 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

Auth for Use/Discl of PHI
8120-0328 adm11
REV: 04/14/2017

LAWRENCE MEMORIAL HOSPITAL

Patient Label