



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 (FORMER PHYSICIAN): _____ Name of Facility/Provider _____ Address _____ City State Zip _____ Phone _____	PHI - RELEASE TO: Lawrence Endocrinology 1130 W 4 th Street, Suite 3200 Lawrence, KS 66044-1328 Phone: (785) 505-5885 Fax: (785)505-3322
PURPOSE OF DISCLOSURE: _____ _____	EXPIRATION DATE OF AUTHORIZATION: _____ If not noted – this authorization will expire 90 days from the date it was signed.

<table> <thead> <tr> <th>REPORT</th> <th>VISIT DATE(S)</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Final Case Summary</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> History & Physical</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Consultation</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Operative/Procedure</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Lab/Pathology</td> <td>_____</td> </tr> </tbody> </table>	REPORT	VISIT DATE(S)	<input type="checkbox"/> Final Case Summary	_____	<input type="checkbox"/> History & Physical	_____	<input type="checkbox"/> Consultation	_____	<input type="checkbox"/> Operative/Procedure	_____	<input type="checkbox"/> Lab/Pathology	_____	<table> <thead> <tr> <th>REPORT</th> <th>VISIT DATE(S)</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Radiology/Imaging</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Emergency Dept.</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other (List)</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Physician Office (specify)</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td>_____</td> </tr> </tbody> </table>	REPORT	VISIT DATE(S)	<input type="checkbox"/> Radiology/Imaging	_____	<input type="checkbox"/> Emergency Dept.	_____	<input type="checkbox"/> Other (List)	_____	<input type="checkbox"/> Physician Office (specify)	_____	<input type="checkbox"/> _____	_____
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YES		NO											
_____	DRUG & ALCOHOL PHI	_____											
_____	HIV/AIDS PHI	_____											
_____	GENETIC TESTING	_____											

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