# PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

LMH Health 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: ______________________________ Date of Birth: ____/____/________

Address: ______________________ City:______________ State:______ Zip:__________

Email Address:______________________________ Phone:________________

**I request that my protected health information (PHI) from LMH Health be disclosed to:**

Recipient Name:________________________________________________

Address: ______________________ City:______________ State:______ Zip:__________

Email Address:______________________________ Phone:________________

Fax (healthcare provider only):________________________________________

**Purpose for requesting information:** ☐ Personal ☐ Continuation of Medical Care ☐ Insurance ☐ Legal

**Covering the period of healthcare from:** Date(s):__________ to __________

**I authorize the following PHI to be released from my medical record(s):**

☐ Emergency Room Record ☐ History & Physical ☐ Consultation ☐ Operation/Procedure

☐ Laboratory/Pathology Reports ☐ Radiology Reports ☐ Final Case Summary

☐ Physician Office Records (specify clinic(s)):________________________________

☐ Test Result(s) of:________________________________________

☐ Other:________________________________________________

**State and federal law protect the following types of information. If this applies to you, please indicate if you would like this information to be released by placing your *initials* below.**

| Yes | | No* |
|---|---|---|
| ________ | Alcohol, Drug, or Substance Abuse Records | ________ |
| ________ | HIV Testing and Results | ________ |
| ________ | Mental Health Records | ________ |
| ________ | Psychotherapy Records | ________ |
| ________ | Sensitive Records | ________ |
| ________ | Genetic Records | ________ |

***Any information listed above, not initialed, will not be included.**

**Disclosure Format** (Paper is default if not marked)**:** ☐ US Mail ☐ Secure CD ☐ Pick-Up ☐ Fax ☐ Patient Portal ☐ Secure E-mail (file size limit) ☐ Other:__________________

**By signing this authorization form, I understand that:**

- **I authorize Lawrence Memorial Hospital to disclose the identified information to the person(s) and for purpose described herein.**
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Services Department at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: ______________________. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

______________________________________ ______________________

*Signature of Patient, Guardian or authorized representative* *Date*

______________________________

*If signed by other than the patient, relationship to patient*

The Lawrence Memorial Hospital DBA
LMH Health
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