# PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| Patient Name: | | Maiden Name: | |
|---|---|---|---|
| Date of Birth: | Last 4 of SSN: | Phone Number: | |
| Street Address: | City: | State: | Zip Code: |

**The following organization is authorized to make the disclosure:**
□LMH Health Organization □Lawrence Memorial Hospital □Lawrence Primary Care, *specify Clinic or Provider*: ____________
□Other Physician/Hospital/Clinic *(OrthoKS, Lawrence Cancer Care, etc.)* ____________

**The type of information to be disclosed:**
□Abstract *(including history & physical, consults, operative notes, emergency record, lab, radiology, and cardiology reports)*
□Complete Medical Record *(every page of the chart including but not limited to notes, orders, consent forms, etc.)*
□Clinic Records *(including but not limited to history & physical, consults, clinic records, labs, diagnostic reports, etc.)*
□Billing Records □Radiology (Images Only) □Other, *specify*: ____________

**Date Range of Service:**____________to ____________

**This information may be disclosed to and used by the following individual / organization:**

| Recipient Name: | | Phone Number: | |
|---|---|---|---|
| Street Address: | City: | State: | Zip Code: |

**For the Purpose of:** □Continuity of care □Legal □Personal Records □Other, *specify*:____________

**Delivery Method:** □In-Person Pick Up □Mail to Recipient Address □Fax to:____________
□eDelivery to Email Address* *(Patient Requests only)*: ____________
** I attest that I have provided a valid e-mail address. I understand that a secure link for record access will be emailed to me from a third party release of information vendor.*
□Other Delivery Method, *specify*:____________If needed for a doctor's appointment, *specify date*: ____________

**42 CFR Part 2.** Regulations found at 42 CFR Part 2 impose additional protections on information created by certain programs related to alcohol and substance use and treatment. To the extent applicable to your records, these records will not be included unless separate authorization is included.

The undersigned herby authorizes the use and/or disclosure of the above named individual's health information as described in this authorization.

- I understand that this authorization is voluntary and I am not required to sign it to receive healthcare services, payment, enrollment or eligibility for benefits.
- 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.
    - This authorization shall expire on ____________ or one (1) year from the date of signature, whichever occurs first.
- Any disclosure of information carries with it the potential for redisclosure by the recipient and the information may not be protected by federal confidentiality rules.

**I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

Signature of Patient / Authorized Representative____________Date ____________

***If signed by Authorized Representative, please complete the following:***
Authorized Representative's Printed Name: ____________
Relationship to Patient:____________Phone Number: ____________

| **Department Use Only:** *Driver's License or Photo ID required when records are picked up.* Witness Signature: ____________ |
|---|
| DL State:______ID Number:______Relationship to Patient:______Date/Time: ______ |

The Lawrence Memorial Hospital DBA
LMHHealth
325 Maine Street, Lawrence, KS 66044

## Instructions for completing the Authorization to Release Information:

1. Complete the first section with your current name, date of birth, current address, and daytime telephone number.

2. Select the organization authorized to make the disclosure.

3. Select the records you want.
   a. Billing records are NOT kept in the Health Information Management Department. If you are requesting billing records ONLY, mail this form to the attention of Patient Accounts at 325 Maine Street, Lawrence, KS 66044 or fax to 785-505-5239. You may call Patient Accounts at 785-505-2922.
   b. Radiology images are NOT kept in the Health Information Management Department. If you are requesting radiology images ONLY, mail this form to the attention of Imaging Department, 325 Maine Street, Lawrence, KS 66044 or fax to 785-505-5266. You may call Imaging Department at 785-505-6194.

4. Specify dates of service authorized for use/disclosure. Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.

5. Complete the recipient section with the name, address, and contact information of the individual / organization whom you are authorizing disclosure to.
   a. If records are going to be picked up by someone other than the patient, please complete this recipient section for the information of the individual who is picking up the records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.

6. Specify if the purpose for this disclosure is for continuity of care, legal, personal records or other.

7. Select the method you'd like your records to be delivered in and if applicable, provide the appropriate information in the blank next to your selection. If you select *eDelivery to Email Address*, you are attesting that you have provided a valid e-mail address. A secure link for record access will be emailed to you from our third party release of information vendor.

8. This form should be signed and dated by the patient. If the patient is unable to sign and the request is being made by an authorized personal representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate, etc.), the Authorized Representative should sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this form when signed by an Authorized Representative.

For more information **OR** if you would like to complete a request electronically, please visit our website at https://www.lmh.org/patients-visitors/medical-records/release-of-information/

If you have further questions, you may contact Health Information Management at (785) 505-3093.

Please submit your completed form
to: LMH Health
Attn: HIMS
325 Maine Street
Lawrence, KS 66044

E-Mail: medicalrecords@lmh.org

Fax: (785) 505-5222

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325 Maine Street, Lawrence, KS 66044