AUTHORIZATION TO RELEASE PHI

SOURCE: __HIM_____

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION (PHI)

***INDICATES REQUIRED FIELDS. REQUEST WILL NOT BE HONORED IF THOSE FIELDS ARE NOT COMPLETED.**

***PATIENT IDENTIFICATION**

Name: _____ DOB: _____ SS#: _____ Date: _____

Street Address: _____ City, State, Zip: _____

Phone number: _____ *Email address: _____

I HEREBY AUTHORIZE:

*Name of Provider/Healthcare Facility:

_____

*Street Address: _____

*City, State, Zip Code: _____

*Phone #: _____

Fax #: _____

*Preferred Format: ☐ Paper ☐ Electronic Format

TO RELEASE TO:

*Provider/Healthcare Facility/Other:

_____

*Street Address: _____

*City, State, Zip Code: _____

*Phone #: _____

Fax #: _____

Send Attn: ☐ Provider: _____

☐ Medical Records ☐ Date needed by: _____

PURPOSE OR NEED FOR DISCLOSURE:

☐ Legal ☐ Transferring of care ☐ Seeking 2nd opinion

☐ Continued care ☐ Insurance application ☐ Other: _____

***INFORMATION TO BE RELEASED:**

☐ Complete records ☐ Lab reports ☐ X-ray reports

☐ Provider's notes /H&P ☐ Consult reports ☐ X-ray images (released by the Radiology department at Lakewood Health System)

☐ Nurses' notes ☐ Rehab services ☐ Other:

***RECORDS FROM THE TIME PERIOD:**

Specify date(s): _____ to: _____

***IN COMPLIANCE WITH FEDERAL AND STATE LAWS:**

In compliance with Federal and State laws which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcoholism ☐ Mental health ☐ HIV test results. AIDS, or AIDS-related disease ☐ Not applicable

☐ Drug abuse ☐ Developmental disabilities ☐ Genetic testing

I authorize release of my medical records in accordance with the specifications listed above. I understand that this authorization does not expire unless I revoke or provide expiration date here _____. I understand that Lakewood Health System takes no responsibility for the safe arrival of medical records that are taken by the patient. Lakewood Health System reserves the right to charge for the copying of medical records as permitted by law. **Photocopies of the authorization will be accepted in lieu of the original.**

* Signature of Patient or Legal Guardian:	* Date:	Relationship of Guardian to Patient:	Date:
_____	_____	_____	_____

Person authorized by the patient means the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives deceased patient, an adult member of the deceased patient's immediate family may qualify. A court appointed temporary guardian may also qualify to consent to the release of records.

Patient is: ☐ Minor ☐ Disabled ☐ Incompetent ☐ Deceased

Legal Authority: ☐ Legal guardian ☐ Next of kin

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Release of Information Phone: 218-894-8064
Fax: 218-894-8552