Authorization for Use or Disclosure of Medical Record Information for Other Facilities

Patient Information

** Please Print **

Patient Full Name: _____

Patient Address: _____

City: _____ State _____ Zip: _____

Date of Birth: _____

Email Address: _____

Home Phone: _____

Work Phone: _____

Release Information to

I hereby authorize _____ *to release my medical record information to:*

☐ Mail Copies To:

Name/Facility: _____

Address: _____

City: _____ State _____ Zip: _____

Attention: _____

Phone: _____

Fax: _____

Purpose of Request:
- ○ Personal
- ○ Continuing Care (second opinion or refer to specialist)
- ○ Insurance
- ○ Legal
- ○ Transfer Out of Lahey _____

_____ Preferred Output? *(paper is default)* _____

Information to be Released

☐ Please provide a 2 year abstract of my medical information

☐ Please provide an abstract of my entire medical record

☐ Other - please be specific, include dates and MDs in comments

Comments

Authorization to Release Protected Information

*Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Initial each line below to confirm your choices

I ☐ DO   ☐ DO NOT want *Psychiatric Treatment Notes released _____

I ☐ DO   ☐ DO NOT want information about *Mental Health released _____

I ☐ DO   ☐ DO NOT want information about *HIV Tests & Related Information released _____

I ☐ DO   ☐ DO NOT want information about *Alcohol and/or Substance Abuse released _____

I ☐ DO   ☐ DO NOT want information about *Genetic Testing released _____

I ☐ DO   ☐ DO NOT want information about _____ released _____
Other sensitive information?

STOP Please confirm that you have put a <u>checkmark</u> and <u>initialed</u> ALL the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, Lahey may be unable to fulfill this request.

Sign Here ▷

_____   **Patient's Signature**

Date Here ▷

_____   **Date***

_____   **Parent/Legally Recognized Representative Signature****

_____   **Date***

Refer to the HIPAA
"PRIVACY NOTICE"

_____   **Witness**

_____   **Date**

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise:_____. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that Lahey has already completed action on it.

**By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following:_____.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Lahey will not condition treatment on payment of the provision of this Authorization.

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PATIENT INFORMATION

Lahey CLINIC