

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION FOR OTHER FACILITIES

Patient Full Name: _____	Medical Record #: _____
Patient Address: _____	Date of Birth: _____
_____	Home Phone: _____
	Work Phone: _____

I HEREBY AUTHORIZE: _____
(write in name of non-Lahey provider or entity)

- To release my Medical Record information to:
 To speak about my Medical Record information with:
 To fax to the location below:

Other: _____
 Name/Facility: _____
 Attention: _____
 Address: _____
 Fax#: _____

INFORMATION NEEDED (Be specific, include provider name and dates of treatment, if applicable): _____

AUTHORIZATION FOR RELEASE OF SENSITIVE OR STATUTORILY PROTECTED INFORMATION.

IMPORTANT: If your Medical Records contains information in any of the following areas and you want this information to be included in your request, you need to indicate your authorization by initializing next to the corresponding category(ies).

	YES Release	NO Do not Release	Initials		YES Release	NO Do not Release	Initials
Abortion				AIDS/ARC			
Alcohol Abuse				HIV Tests or related information			
Substance Abuse				Domestic/Sexual Assault			
Mental Health				Sexually Transmitted Disease			
Genetic Testing				Other:			

Any other information that you would like withheld under this release _____

Patient's Signature **Date***

KNOW YOUR PRIVACY RIGHT
refer to the HIPAA
"PRIVACY NOTICE"

Parent/Legally Recognized Representative Signature** **Date***

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 released 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 or payment on the provision of this Authorization.