Authorization For Use or Disclosure of Medical Record Information

41 Mall Road
Burlington, MA 01805

Phone: 781-744-8041 Fax: 781-744-1164

LC Number: _____

Patient Information

*** Please Print ****

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Email Address: _____

City: _____ State _____ Zip: _____ Home Phone: _____

Work Phone: _____

Release Information to

I hereby authorize Lahey Clinic, Inc. & Lahey Clinic Hospital to release my medical record information to:

☐ Mail Copies To: ☐ Discuss Medical Record Information With: Hold For Pick-up At: ☐ Burlington ☐ Peabody ☐ Lexington

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ 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
*Note you will be invoiced at the allowable MA Statute rate

☐ Please provide an abstract of my entire medical record
*Note you will be invoiced at the allowable MA Statute rate

☐ Other - please be specific, include dates and MDs in comments
*Note you will be invoiced at the allowable MA Statute rate

Comments

*For current Massachusetts and New Hampshire Statute Copy Fees, please see Lahey Clinic's web site at www.lahey.org/Patients/MedReq.asp

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 ***Sexually Transmitted Diseases** 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 checkmark and initialed **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 **Date Here**

Patient's Signature **Date***

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

Witness **Date**

Know Your Privacy Rights
Refer to the HIPAA
"PRIVACY NOTICE"

*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.

For Diagnostic Imaging Please Turn to Next Page.

Authorization For Release of Diagnostic Images

Diagnostic Radiology Department, Image Management Center

Tel: 781-744-3208 | ***Fax: 781-744-5363*** | ***Date:*** _____

(Please Print)

Patient Information

LC Number: _____

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Information to be Released

PLEASE BE SPECIFIC - include dates of exam and type if applicable.

_____ Date(s) of Treatment _____

_____

Mail Images to

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Patient will pick up on

_____

If the patient sends someone else to pick up the CD/FILMS, they must have a signed authorization from the patient before we can release them.

Release Information

I am authorizing the release of the above images. The CD is mine to keep.

Signature of Patient/Legal Guardian: _____

Fax this authorization to the IMC. A CD will be burned with the x-ray images on it.

Copy fee: We reserve the right to charge a reasonable fee for the cost of producing and mailing copies.

If you have any additional questions or are unsure of which images you need, please call the IMC Department at 781-744-3208.

Please allow at least 2 business days for your request to be processed. We will do it sooner if possible.