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

Patient Information

** Please Print **

Patient Full Name: ______________________ Date of Birth: ______________________

Email Address: ______________________

Patient Address: ______________________ Home Phone: ______________________

City: ______________ State ________ Zip: ____________ Work Phone: ______________________

Release Information to

I hereby authorize ______________________ to release my medical record information to:

☐ Mail Copies To:

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)*

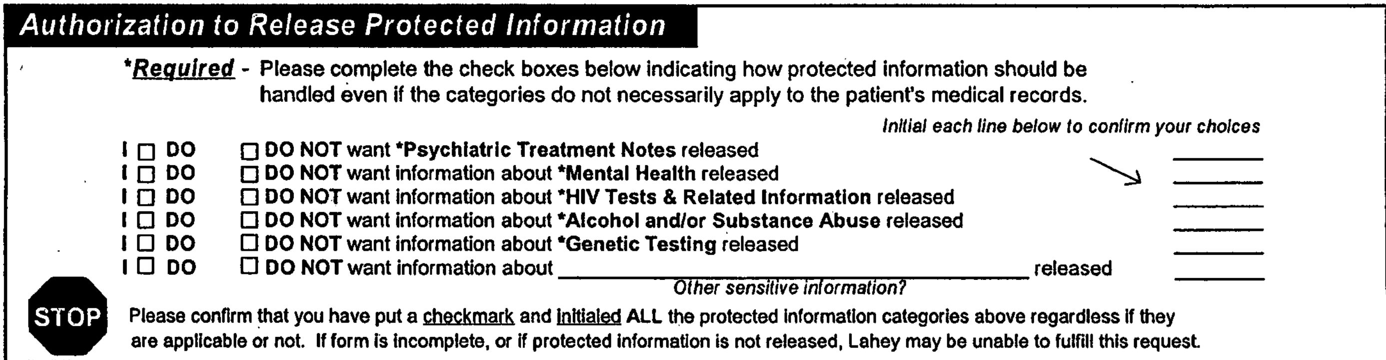
Information to be Released

☐ Please provide a 2 year abstract of my medical information

☐ 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 __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**

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.

PATIENT INFORMATION