

Licking Memorial Health Systems

Authorization for Release of Medical Information

ID verified Minor Staff initials: _____ Medical Record #: _____ (completed by LMHS)

Patient Information	Patient name: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle initial Maiden (if applicable) </div> Address: _____ City: _____ State: _____ Zip: _____ Date of birth: _____ Social Security # (last 4 digits): _____ Work phone: () _____ Home phone: () _____
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Release To / From	<p>I hereby authorize Licking Memorial Health Systems to: (Please check only one box)</p> <p><input type="checkbox"/> Release my records to: <input type="checkbox"/> Obtain my information from:</p> Name / facility: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone: () _____ Fax: () _____ Information may be: <input type="checkbox"/> Mailed <input type="checkbox"/> Released to MyChart (Patients only) <input type="checkbox"/> Secure email: (Email address) _____ <input type="checkbox"/> Reviewed only <input type="checkbox"/> Verbal exchange <input type="checkbox"/> Fax: _____ <input type="checkbox"/> Picked up by: _____ Copy my medical records to: (Please check one) <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Electronic copy (PDF) <input type="checkbox"/> Electronic link Documentation can be released in an electronic format if stored in electronic media. Please check with Medical Records at 220-564-4132 to determine if your health information is available for electronic release.
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Purpose of Disclosure	<p>Records are to be released for the following purpose(s): (Please check all that apply)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Continuity of care / medical treatment <input type="checkbox"/> Personal use <input type="checkbox"/> Changing doctor <input type="checkbox"/> Other: _____ </div> <div style="width: 50%;"> <input type="checkbox"/> Attorney / legal <input type="checkbox"/> Insurance </div> </div>
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Information Needed	<p>Dates of Service(s) to be released: (specify dates - this line <u>MUST BE</u> completed)</p> <p>_____</p> <p>The information being requested is: (Please check all that apply)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Discharge summary <input type="checkbox"/> Consults <input type="checkbox"/> Procedure reports <input type="checkbox"/> Labs <input type="checkbox"/> Cardiac studies <input type="checkbox"/> Occupational Health records <input type="checkbox"/> Discharge instructions <input type="checkbox"/> Drug / alcohol information <input type="checkbox"/> Home health records <input type="checkbox"/> Other: _____ </div> <div style="width: 50%;"> <input type="checkbox"/> History and physical <input type="checkbox"/> Operative <input type="checkbox"/> Emergency department report <input type="checkbox"/> Imaging / radiology reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Physician progress notes <input type="checkbox"/> Psychological tests <input type="checkbox"/> Radiology images / films <input type="checkbox"/> Nursing notes </div> </div>
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Please place patient label here



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Information Needed (Con't)	<p>NOTE: If applicable, Psychotherapy notes require a separate authorization.</p> <p>Mental Health, drug and alcohol, and communicable diseases including HIV (AIDS) or related illness may be contained in the parts of the records indicated above and will be released through this authorization unless otherwise indicated:</p> <p>DO NOT RELEASE: <input type="checkbox"/> HIV (AIDS) <input type="checkbox"/> Mental Health <input type="checkbox"/> Drug & Alcohol</p>
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Authorization	<p>Authorization and Expiration:</p> <p>This authorization will expire one year from the date it is signed unless it is otherwise revoked (withdrawn), or if specified on the following date, event or condition _____, not to exceed one year and covers only the dates of service specified above.</p> <ul style="list-style-type: none"> ● I have read the above and authorize the staff at Licking Memorial Health Systems to disclose information from my medical record for the reasons and time specified to the party (parties) named in this document. ● I understand this authorization may be revoked (withdrawn) by me at any time, providing the information has not already been disclosed. ● I understand that once the information has been disclosed per my instruction, the information may no longer be protected by federal confidentiality laws. ● I understand that my treatment, payment, enrollment or eligibility benefits may not be conditioned on signing this authorization. Licking Memorial Health Systems is permitted to disclose my health information for treatment, payment, and operation purposes. Licking Memorial Health Systems is released and discharged of any liability and the undersigned will hold Licking Memorial Health Systems harmless for complying with this "Authorization for Release of Medical Information." ● If applicable, a separate authorization will be required to release your psychotherapy notes. ● You are entitled to a copy of this form. Please verbally request it, if you want a copy. ● I understand there may be charges for copying and release of this information. <p>Patient (or patient's legal representative) signature: X _____ Date: _____ Time: _____</p> <p>Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Other: _____</p>
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Redisclosure	<p>Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.</p>
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Revocation	<p><input type="checkbox"/> I elect to revoke this authorization except to the extent that Licking Memorial Health Systems has relied on my previous authorization. This revocation will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.</p> <p>Patient (or patient's legal representative) signature: X _____ Date: _____ Time: _____</p> <p>Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Other: _____</p>
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