Licking Memorial Health Systems
Authorization for Release of Medical Information

☐ ID verified ☐ Minor Staff initials: _______ Medical Record #: ____________________ (completed by LMHS)

Patient Information

Patient name: ____
Last First Middle initial Maiden (if applicable)

Address: ______________________ City: ______________ State: _______ Zip: __________

Date of birth: __________________ Social Security No: ______________________

Work phone: ( ) ____________________ Home phone: ( ) ____________________

Release To / From

I hereby Authorize Licking Memorial Health Systems to: (Please check only one box)

☐ Release my records to: ☐ Obtain my information from:

Name / facility: ____

Address: ______________________ City: ______________ State: _______ Zip: __________

Telephone: ( ) ____________________ Fax: ( ) ____________________

Information may be:

☐ Mailed ☐ Reviewed only ☐ Verbal exchange ☐ Fax: __________ ☐ Picked up by: __________

Copy my medical records to: (Please check one) ☐ Paper ☐ CD

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.

Purpose of Disclosure

Records are to be released for the following purpose(s): (Please check all that apply)

☐ Continuity of care / medical treatment
☐ Personal use
☐ Changing doctor
☐ Other: ____
☐ Attorney / legal
☐ Insurance

Information Needed

Dates of Service(s) to be released: (specify dates - this line MUST BE completed)

____

The information being requested is: (Please check all that apply)

☐ Discharge summary
☐ Consults
☐ Procedure reports
☐ Labs
☐ Cardiac studies
☐ Occupational Health records
☐ Discharge instructions
☐ Drug / alcohol information
☐ Home health records
☐ Other: ____
☐ History and physical
☐ Operative
☐ Emergency department report
☐ Imaging / radiology reports
☐ Physician orders
☐ Physician progress notes
☐ Psychological tests
☐ Radiology images / films
☐ Nursing notes

Please place patient label here

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Medical Record #: ____________________ (completed by LMHS)

Information Needed (Con't)

NOTE: If applicable, Psychotherapy notes require a separate authorization.

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:

Do not release: ☐ HIV (AIDS) ☐ Mental Health ☐ Drug & Alcohol

Authorization

Authorization and Expiration:

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.

- 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.

Patient (or patient's legal representative) signature: X______________________________ Date:______ Time:______

Relationship to patient: ☐ Self ☐ Other: ______________________________

Redisclosure

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.

Revocation

☐ 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.

Patient (or patient's legal representative) signature: X______________________________ Date:______ Time:______

Relationship to patient: ☐ Self ☐ Other: ______________________________

Please place patient label here

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