



AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

_____ Name of Facility

_____ Address

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: _____

- | | |
|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports) |
| <input type="checkbox"/> History & Physical (H&P) | <input type="checkbox"/> X-ray and imaging reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Laboratory Test Results |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Immunization Record |

Other- list specific Items: _____

Behavioral Health Reports:

- | | |
|--|---|
| <input type="checkbox"/> Social History | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Client Data Form | <input type="checkbox"/> Academic History |
| <input type="checkbox"/> Referral/Treatment Form | <input type="checkbox"/> Aftercare Instructions |
| <input type="checkbox"/> Admission Evaluation | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Notification of Admission | |

Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol/drug abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

- 4. I understand that your facility may receive compensation for medical record copying in accordance with State law.
- 5. This information may be disclosed to and used by the following individual/organization:

Name: Lakeshore Internal Medicine

Address: 134 Medical Park Rd, Ste 108, Mooresville, NC 28117

For the purpose of:

- | | | |
|--|---|---|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Inspection/Copying of my records |
| <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Personal | |
| <input type="checkbox"/> Changing Physicians | <input type="checkbox"/> Other (please specify): _____ | |

- 6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.
- 7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- 8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.
- 9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

 Signature of Patient Date
 (If signed by person other than the patient, state relationship and authority to do so.)

Name of Patient (Please Print)

- Patient is: Minor Incompetent Disabled Deceased
- Legal Authority: Custodial Parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Health Care Authorized Legal Personal Representative

 Signature of Witness Date