Lakewood Ranch Medical Center

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Name:	Birth Date:	Social Security Number: *(optional)*
Recipient's Name:		
Address 1:		
Address 2:		
City:	State:	Zip:

This authorization will expire on the following: Fill in the Date or the Event but not both.

Date: _____ Event: _____

Medical Record Number *(completed by facility personnel)*

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below:

☐ No, then you may check as many items below as you need.

Type of Access Requested:	Date(s): *Must* include	Description *Check off what is needed*	Date(s): *Must* include	Description *Check off what is needed*	Date(s): *Must* include
☐ Copies of the record	_____	☐ Abstract/Pertinent	_____	☐ Lab	_____
		☐ Emergency Room	_____	☐ Imaging/Radiology	_____
		☐ H & P	_____	☐ Cardiac Studies	_____
	_____	☐ Consult Report	_____	☐ Face Sheet	_____
☐ Inspection of the record		☐ Operative Report	_____	☐ Nursing Notes	_____
		☐ Rehab Services	_____	☐ Medication Record	_____
		☐ Progress Notes	_____	☐ Discharge Summary	_____
		☐ Physician Orders	_____	☐ Entire Record	_____
		☐ Pathology	_____	☐ Other _____	_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. Initials _____ If not applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned to signing this authorization.
3. I may revoke this authorization at any time in writing; but if I do, it 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.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated:

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient/Representative:	Relationship to Patient:

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