**Authorization for Release of Health Information**

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**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR**

|  |  |
| --- | --- |
|  I authorize Lexington Regional Health  Center to ***RELEASE*** information to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of provider or facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # Fax # |   I Authorize Lexington Regional Health  Center to ***OBTAIN*** my records from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of provider or facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # Fax # |

**Purpose(s) of Disclosure**:

[ ]  If the purpose for the disclosure is marketing, check this box only if Lexington Regional Health Center *will* receive direct or indirect remuneration from a third party.

**Information to be disclosed:**

[ ]  Complete medical records from the past 2 years will be sent unless otherwise specified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**.** This will include ER records, lab results, x-ray reports, discharge summary, operative report.

[ ]  Date of service or time period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ]  Other**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 **I specifically authorize the release of information relating to:**

[ ]  Substance abuse (including alcohol/drug abuse)

[ ]  HIV/AIDS related information (including test results)

[ ]  Mental Health

**Expiration date, event, or condition:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in twelve months from the date signed.

My refusal to sign this authorization will not affect my ability to obtain treatment at Lexington Regional Health Center and its entities. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law. I understand that I may revoke this authorization at any time by giving written notice to Lexington Regional Health Center. My revocation will not be effective to the extent action has already been taken in reliance on my authorization. I have read (or had read to me) and have received a copy of this document. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

 \_\_\_\_

Signature of patient or patient’s personal representative Date

Relationship to patient if signed by personal representative