LEXARECORDS
Medical Records Management Company

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

PHONE (_____ **ALT. PHONE** (_____) _____

EMAIL ADDRESS : _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____

Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____ Email: _____

REASON FOR DISCLOSURE (Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing, Claims, or Insurance
- ☐ Health Oversight Activities *(complete page 3)*
- ☐ Legal Purposes *(complete page 3)*
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

METHOD OF RELEASE ☐ **Email** ☐ **Mail** ☐ **Fax**

WHAT INFORMATION CAN BE DISCLOSED?

Date of Service: _____

☐ All Health Information	☐ Patient Allergies	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Physician's Orders	☐ Discharge Summary	☐ Radiology Reports	☐ Other
☐ Progress Notes	☐ Billing Information	☐ Radiology Images	
☐ Pathology Reports	☐ Past/Present Medications	☐ Lab Results	
☐ History/Physical Exam	☐ Operation Reports	☐ Consultation Reports	

Your initials are required if you wish to release any of the following information:

_____Mental Health Records (excluding psychotherapy notes), Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including Genetic Test Results), HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable):

If representative, specify relationship to the individual: o Parent of minor o Guardian o Other:

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PROHIBITED USE ATTESTATION

Patient Name: _____

Requester Name: _____

Recipient Name: _____

Select the purpose of the information you are requesting:

☐ health oversight activities ☐ judicial and administrative proceedings

☐ law enforcement purposes ☐ disclosures about decedents to coroners and medical examiners

Description and date range of records being requested:

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (please check one):

☐ This information is **not** intended for use in criminal, civil, or administrative investigations or proceedings against persons for "mere act of" seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it is provided. *No further information is required. Proceed to end and sign.*

☐ This information is intended for use in criminal, civil, or administrative investigations or proceedings against persons for obtaining reproductive health care that was against the law at the time and in the location, it was provided. Supporting documentation is attached.

Documentation to support the determination that the services in question were illegal at the time and place they were performed is required.

Supporting documentation and the totality of the request for information is subject to review by the covered entity.

Attestation: By signing this form, I do hereby attest that this information is true and accurate to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability pursuant to 42 U.S.C. 1320d-6.

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Institution:

For more information please refer to the Final Rule:
https://www.federalregister.gov/documents/2024/04/26/2024-08503/hipaa-privacy-rule-to-support-reproductive-health-care-privacy

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