Lexa Records
Medical Records Management

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earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____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: