Lakeland Health

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Release health information for the following individual:

Name of Individual: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____

Purpose of Disclosure: You're not required to tell us the purpose of your request. If you don't wish to tell us, simply check the box marked 'Other'.

□ At my request
□ Changing doctors
□ Continuing care
□ For my own use
□ Insurance or Worker's Compensation
□ Legal
□ Military
□ School
□ Other_____

I am requesting records <u>from</u> the following Lakeland Health location(s)

☐ Lakeland Hospital, Saint Joseph
☐ Lakeland Hospital, Niles
☐ Lakeland Hospital, Watervliet

☐ Clinic Location (specify below)

Clinic: _____

Address: _____

Information to be released:

☐ **Complete Medical Record(s)**
Key Clinical Written Documentation (includes, as applicable, History & Physical, Discharge Summary, Operative Reports, Consults, Diagnostic Reports, ER Notes) related to a specific incident, injury or illness from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

OR

☐ **Individual Reports:** from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐Admission Evaluation
☐Cardiac Records
☐Consults
☐Discharge Summary
☐History & Physical
☐Lab Reports
☐Medication Records
☐Emergency Room Report
☐Face Sheet
☐Operative Report/Device & Lot #
☐Psychiatric Admission
☐Pathology Report
☐Radiology Report

☐ Pathology Slides - **Released by the Pathology Department**
☐ Radiology Images on CD - **Released by the Radiology Department**
☐ Other (Please Specify): _____

Its director or agent, to disclose information contained in the medical records of the patient identified above, which included information that may be stored in a paper and/or electronic format. Such notes may contain information on general medical care, psychological & social work counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis & hepatitis, demographic information, and treatment received at other health care providers. Any alcohol and substance abuse information disclosed to you from records are protected by Federal confidentiality rules (42 CFPR part 2). The Federal rules prohibit you from making any further disclosure of its information unless further disclosure is expressly permitted by the written content of the person whom it pertains or as otherwise permitted by 42 CFR part 2.

Only check the boxes below if you do NOT wish to release this information in the medical records

☐Alcohol & Substance/Drug Abuse diagnosis & treatment

☐Psychotherapy Notes

Who will receive this patient's protected health information?

☐Myself ☐ Other: I am the patient, or the legally authorized representative of the patient listed above & request Lakeland Health to release my Protected Health Information to:

Name: _____ Company: _____
Address: _____ Telephone#: _____
City/State/Zip: _____ Fax#: _____

_____ _____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) **DATE (mm/dd/yyyy)**

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship to Patient: ☐Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ DPOA for Healthcare

Select Delivery Method: ☐ US Mail ☐ Pick Up ☐ MyChart

Select Delivery Format: ☐ CD ☐ USB Drive ☐ MyChart ☐ Paper

This authorization is valid only if received by Lakeland Health within 60 days of the date signed. This authorization expires when the patient information is disclosed as permitted in this authorization. A copy or fax of this authorization is valid.

I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

My care or treatment will not be conditioned on signing the authorization.

The persons to whom information is disclosed under the authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal & health information may no longer be protected by law.

Lakeland Health and/or its copying services reserve the right to charge for processing and copying information. The fee is waived when releasing information directly to a treating physician or healthcare facility.

Fees:	**CD***	**$6.50**
	Thumb/USB Drive*	**$6.50**
	MyChart	**FREE**
	Paper	**$6.50 if < 200 pages or 4 cents per page if > 200 pages**

*** Provided by Lakeland Medical Records Department**