Lake Health

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Label

Part A:

☐ **Tripoint Medical Center** ☐ **Perry Walk-in** ☐ **Mentor Medical Campus** ☐ **Lake Health Physician Group**
☐ **West Medical Center** ☐ **Lake Health Diagnostic Centers** ☐ **Lake Health Sleep Center** ☐ **Mentor Physical Therapy**
Urgent Care Centers: ☐ **Willowick** ☐ **Tyler** ☐ **Madison** ☐ **Chardon** ☐ **Painesville**

Name of Patient:_____
Last First Maiden / AKA

Address:_____

Date of Birth:_____ Home Phone:_____ MR #:_____

Email Address:_____

INFORMATION TO BE:

☐ Released to:_____ ☐ Obtained from:_____

I hereby authorize Lake Health / Lake Health Physician Group to release to/or obtain from the following facility, the information as specified below:

Facility/Name:_____
Phone #: _____ Fax #:_____
Address:_____
Date(s) of Treatment:_____
Reason for Treatment:_____

INFORMATION TO BE RELEASED/OBTAINED: ☐ Pertinent Summary (Includes all * items):

☐ Demographic / Facesheet	☐ Pathology Report *	☐ Radiology Report *	☐ Drug / Alcohol Info
☐ History & Physical *	☐ Consultation Report *	☐ Radiology Films	☐ EKG Report *
☐ ER Report *	☐ Entire Record	☐ Lab Reports *	☐ Cardiac Cath Report *
☐ Discharge Summary *	☐ Physical Therapy	☐ Psychiatric Info	☐ HIV / AIDS Info
☐ Operative Note *	☐ Other:_____		

PURPOSE OF DISCLOSURE: ☐ Continued Treatment ☐ Personal Use ☐ Legal ☐ Other Specific Use_____

To be completed by the Organization if this authorization is for marketing, fundraising, research, or sale of Protected Health Information:
The organization will receive compensation in exchange for using or disclosing the health information as described above: ☐ YES ☐ NO

Upon admission as an inpatient or to an LHPG office practice, you were asked to sign a Consent for Treatment in which you designated that Lake Health could utilize your health information for the purpose of treatment, payment, and other health care operations as defined by law. The above information you have requested to be disclosed requires you to sign an authorization because it is being released to a third party entity outside of Lake Health.

The consent to disclose information may be revoked by you in writing at any time - except those disclosures, made in good faith that have already occurred. This consent expires one year (1) from the date of signature and applies to all services provided and protected health information created by Lake Health prior to the date of this signature.

I certify that this Authorization has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I understand that redisclosure of my medical records by those receiving the above-authorized information may be accomplished without further written authorization and may no longer be protected. I attest that if such redisclosure is made, I will not hold Lake Health responsible.

X _____
Signature of Patient/Parent/Patient Representative/Physician/Other as Allowable by Law

_____ _____ _____
Relationship to Patient ☐ Patient Unable to Sign Date

If signature is other than patient's signature, a copy of all legal documents verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care.) For a deceased patient: A death certificate coupled with executor of administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

Part B: **LH USE ONLY**

Pulled and Verified by:_____ Date:_____
Verify Photo ID by:_____ Date:_____
Method of Disbursement: ☐ Mail ☐ In-person ☐ Faxed ☐ Electronic Disclosure ☐ Other:_____
Forms of Records: ☐ Paper _____ # of pages copied _____ Cost ☐ Electronic # Pages _____ , Cost _____ (Retrieval/Media Fee)
Films returned and verified by:_____ Date:_____
☐ No disclosure made (see Part C).

EX4846

Copies of Medical Records are NOT to be emailed directly to patients. Contact HIM DEPT: Healthport Copy Service to process this request for electronic disclosure.