



PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: (Please print) Birth date: Maiden/previous/other names: (Please print)

THIS WILL AUTHORIZE: (Name of person or organization) (Address)

TO RELEASE INFORMATION TO: (Name of person or organization) (Address)

Please mail Please fax Will pick up

INFORMATION REGARDING:

- All medical records Operative reports Mental health Audiology
Ear, Nose, Throat Consultations History and physical Education (IEP)
Neurologic Lab reports Physical form Treatment plan
Ophthalmology Orthopedic X-ray reports Immunizations
Allergies Other

INFORMATION TO OMIT (CHECK ALL THAT APPLY):

- Mental health records HIV records Substance abuse (Alcohol/Drugs) records Other

PURPOSE OF RELEASE (CHECK ALL THAT APPLY):

- Treatment/Referral Evaluation Insurance purposes Personal use Change of physician

IF YOU ARE CHANGING PHYSICIANS, PLEASE MARK THE REASON (CHECK ALL THAT APPLY):

- Prefer different office location Age of children Physician not in your network
Problems with office staff Inadequate appointment availability Moving out of town
Prefer different physician Other (specify)

LPG will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. You do not have to sign this authorization in order to receive treatment from LPG. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time by providing a written request to the LPG Privacy Officer, except to the extent that we have already acted in reliance upon this authorization.

I authorize the use and disclosure of the medical records and health care information indicated above (please print):

Signature: (Patient must sign if 19 years of age or over; otherwise parent, or legal representative) Print Name:

Relationship to patient if not signed by patient:

Current address: Street City State Zip

Current home phone: () Current work phone: ()

Today's date: This authorization will expire on: (specify an expiration date or event)

PLEASE NOTE: THERE WILL BE A \$50 PER PAGE CHARGE FOR COPYING RECORDS FOR PERSONAL USE (\$20 MAXIMUM) THERE IS NO CHARGE FOR RECORDS SENT DIRECTLY TO ANOTHER MEDICAL FACILITY.

(NOTE: The person signing this authorization is entitled to a copy of this form. If the information being released is for a patient who is 19 years of age or over at the time of the request, the patient must sign this form.)