PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____ Birth date: _____ Maiden/previous/other names: _____
(Please print) (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: _____ Print Name: _____
(Patient must sign if 19 years of age or over; otherwise parent, or legal representative)

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; if blank this form will expire in 6 months)

PLEASE NOTE: THERE WILL BE A $6.00 CHARGE FOR PROVIDING RECORDS FOR PERSONAL USE
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.)

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