AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Lake County Family Practice
9500 Mentor Ave • Suite 100 • Mentor, OH 44060
Telephone: 440-352-4880 • Fax: 440-352-3629

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.

0913-4846