Page 1 of 3

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **[Print Name of Individual** **(i.e., patient, resident or client)]** hereby authorize **CHI Lakewood Health** to use and/or disclose the individually identifiable health information as described below for the following patient:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the following person(s) or organization to receive the information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

|  |  |
| --- | --- |
| \_\_ Abstract (Includes¹) | \_\_ Emergency Room Records |
| \_\_ Discharge Summary /Final Diagnosis¹ | \_\_ Reports of Tests & X-rays |
| \_\_ History and Physical Records¹ | \_\_ Immunization (shot) Record |
| \_\_ Consultation Reports¹ | \_\_ Physical Therapy Notes |
| \_\_ Operations and Procedures¹ | \_\_ Outpatient Clinic Notes |
|  |  |

\_\_ Other\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* If authorization is for *marketing*, indicate if \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will receive compensation in exchange for the use and/or disclosure of the PHI. \_\_\_ YES or \_\_\_ NO

Dates of treatment to be released:

I request the form of release of information be \_\_\_\_ Electronic (Portal) \_\_\_\_ Electronic (Email)

\_\_\_\_ Paper (U.S. Mail or pick up) \_\_\_\_ Other (CD, etc...)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2 of 3

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition,

psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand a fee may be charged for copies of my medical record.

**Prohibition on Conditioning of Authorization:** **CHI Lakewood Health** will not condition treatment on your signing this authorization, unless:

* You are receiving research-related treatment; or
* The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

**Re-disclosure:** I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**Expiration:** This authorization will expire \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert date, event or “once purpose stated above is served”).

**Revocation:**  I understand that I may revoke this authorization at any time by notifying **CHI Lakewood Health** in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that **CHI Lakewood Health** took before it received my revocation letter. For example, **CHI Lakewood Health** cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

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Page 3 of 3

**This Authorization is binding:** The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the

**CHI Lakewood Health** Notice of Privacy Practices.

**\*SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE:**

**\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of individual’s personal representative, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

***FOR INTERNAL PURPOSES ONLY***

When **CHI Lakewood Health**  is requesting an authorization to use health information for its own use, the following provision must be completed:

**Staff Personnel:**

Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was a signed copy provided to the individual? \_\_\_YES \_\_\_NO

Access approved? \_\_\_YES \_\_\_NO