LRGHealthcare

Authorization to Disclose Protected Health Information

Patient Name: _____ Medical Records No: _____

Address: _____ Date of Birth: _____

_____ Phone Number: _____

[ ] I hereby authorize _____ to disclose my health information to:

LRGHealthcare
80 Highland Street
Laconia, NH 03246
Phone: 603-524-3211 x3314
Fax: 603-527-7190
email: medicalrecords@lrgh.org

__LRGH __Advanced Orthopaedic Specialists (AOS) __Occupational Health
__FRH __ Hillside ASC __PT/OT/Speech/Massage Therapy __Sleep
__Lakes Region Surgical Associates __Laconia Internal Medicine
__Provider Practices : _____
__Laconia Clinic (Caring for Women, Dr. Murakami, Family Practice, General surgery, Int Med/Endocrine, Neurology, Ortho/Rheum, Urology)

Please circle all facilities that apply.

For the purpose(s):

[ ] Current treatment [ ] Personal records [ ] Insurance [ ] Worker's Compensation
[ ] Provider transfer [ ] Attorney [ ] Other (specify) _____

Dates of service: _____

Information to be disclosed:

[ ] Abstract (includes all items from the below list or check only those documents needed):

[ ] Emergency Dept. Documentation	[ ] Discharge Summary	[ ] History & Physical
[ ] Consultation	[ ] Laboratory Report	[ ] Imaging Report
[ ] Progress Notes	[ ] Imaging CD	[ ] Medication Records
[ ] Operative Report	[ ] OT/PT Reports	[ ] Office Notes
[ ] Immunizations	[ ] Other: _____	

The following types of information **WILL BE INCLUDED UNLESS** indicated by your initialing below:

Drug and/or alcohol treatment	Initials_____	Psychiatric	Initials_____
Abuse/sexual abuse	Initials_____	Genetic Testing	Initials_____
Sexually Transmitted Diseases	Initials_____	History of abortion	Initials_____
HIV (AIDS) testing/treatment	Initials_____		

I Understand that:

- Upon request, I can inspect or obtain a copy of the information I am authorizing to be release. A fee for the costs of processing this request may be charged.
- Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- LRGHealthcare may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at 603-524-3211 x3314.
- I can revoke this authorization at any time by submitting a request in writing to the Health information Management Services or my provider's office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires six months from the date of signature, or on: _____

I have been offered a copy of this form.

This form must be fully completed before signing.

_____	_____	_____
Signature of patient or Patient's Legal Representative	**Authority or relationship of representative (Attach copy of documentation of authority)**	**Date**