LRGHealthcare

Authorization to Disclose Protected Health Information

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

Patient Name: ____ Medical Records No: ______________________

Address: ____ Date of Birth: ______________________

____ Phone Number: ______________________

[ ] I hereby authorize LRGHealthcare to disclose my health information to: Please Check delivery type: [ ] mail [ ] email

Name of Facility and/or Person: ________________________________ Phone Number: ________________________

Address: ____ Fax Number: ________________________

____ Email address: ________________________

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**