# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

LOWELL GENERAL HOSPITAL

**Please complete in ink.**

Patient's Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

I hereby authorize Lowell General Hospital to disclose my protected health information including copies of my medical record to the person or class of persons listed below:

RECIPIENT/PERSON: _____

Address: _____

**TREATMENT DATES:** _____

**INFORMATION TO BE DISCLOSED (check all that apply):**

- ☐ Emergency Room
- ☐ Operative/Procedure Report
- ☐ Pathology Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ At the request of the individual
- ☐ Other *(please specify)* _____
- ☐ Radiology Exams
- ☐ Laboratory Results
- ☐ Cancer Center
- ☐ Clinic Visit Note
- ☐ Abstract (DS, H&P, OP, Path, Test results)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, assault, domestic violence, genetic testing, sexually transmitted disease, HIV testing, HIV results, or AIDS information. (initials) _____

The above information is released for the following purposes only:

- ☐ Medical Care
- ☐ Legal Matters
- ☐ Insurance
- ☐ Personal
- ☐ Other _____

This authorization expires on /upon: _____
(insert applicable date or event)

**CONTINUED ON SIDE 2 – PATIENT'S SIGNATURE REQUIRED**

LGH
LOWELL GENERAL HOSPITAL

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (CONTINUED)**

## I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke my authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to my receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I can get a copy of this form after I sign it.

I hereby authorize Lowell General Hospital to use or release the health information from the medical record of the person listed on the front side of this form. I have carefully read this form and agree to release the information specified.

_____ _____
Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, the signature of a parent, guardian or other representative is required.

_____ _____
Signature of Personal Representative Date

_____ _____
Print Name Relationship of representative to patient

**<u>If the above signature is that of a patient's representative, Lowell General Hospital must complete the following:</u>**

Lowell General Hospital has verified the identify of _____
*Patient Representative's Name*

by _____ and that in his/her capacity of _____
*Means of Verification (Driver's License, etc.)* *(Description of Authority – husband, wife, etc.)*

he/she is authorized to act on behalf of the patient.

_____ _____
Employee Signature who verified identity Date

**PLEASE COMPLETE ALL AREAS ON THIS FORM. IF ANY AREAS ARE LEFT BLANK, THIS FORM WILL BE RETURNED FOR COMPLETION. <u>THANK YOU</u>.**

**Return To:** **<u>Release of Information</u> - Health Information Management**
**Lowell General Hospital**
**295 Varnum Avenue**
**Lowell, MA 01854**