Lawrence General Hospital

LGH Medical Record #_____

Health Information Services Department
1 General St.
Lawrence, MA 01842-0389

Phone: 978-683-4000 Ext. 2046

Authorization to Use or Disclose Protected Health Information

I hereby authorize Lawrence General Hospital to use or disclose the following protected health information from the medical records of the patient listed below. I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

PATIENT NAME:_____Date of Birth:_____
Please Print

Address:_____
Street **City** **State** **Zip**

Social Security Number:_____ Contact Telephone Number _____

RECIPIENT:

_____
Person or Facility (please print)

_____
Street (please print) City State Zip

Fax #_____

Phone #_____

TREATMENT DATES: From: _____ To: _____

Specify information to be disclosed:

- ☐ Medical Abstract
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ X-Ray
- ☐ Laboratory
- ☐ Operative Report
- ☐ Pathology
- ☐ Emergency Room
- ☐ Other (Please specify)

_____
_____
_____

My Highly Confidential Information: By signing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure pursuant to this Authorization.

Release	Signature	Release	Signature
☐ Mental Health		☐ Abuse of an Adult with a Disability	
☐ Developmental Disability		☐ Rape / Sexual Assault	
☐ HIV/AIDS Testing, Results or Treatment		☐ Child/Elder Abuse and Neglect	
☐ Sexually Transmitted Disease		☐ Genetic Testing	
☐ Alcohol and/or Drug		☐ Social Worker Communication	
☐ Domestic violence		☐ Psychotherapy Notes	

PURPOSE OF THE DISCLOSURE:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other_____

IMPORTANT: PLEASE SIGN AUTHORIZATION FORM ON PAGE 2. THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL REQUIRED ENTRIES ARE COMPLETED AND THE FORM IS SIGNED ON PAGE 2 →

TERM: This Authorization will remain in effect:

- ☐ Until Lawrence General Hospital fulfills this request.
- ☐ From the date of this Authorization until the _____day of_____20_____(Valid for 90 days from this date)
- ☐ Until the following event occurs:_____
- ☐ Other: _____

I understand that once Lawrence General Hospital discloses my health information to the recipient, Lawrence General Hospital cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Lawrence General Hospital may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Lawrence General Hospital; except, however, if my treatment at Lawrence General Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Lawrence General Hospital may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Lawrence General Hospital's Privacy Office at the address listed below. The revocation will be effective immediately upon Lawrence General Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Lawrence General Hospital in reliance on this Authorization before it received my written notice of revocation.

I may contact Lawrence General Hospital's Privacy Officer by mail at, One General St., Lawrence, MA 01842, or by telephone at 978-946-8196.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Lawrence General Hospital to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date/Time**

_____ ☐ I.D Verification_____

Printed Name of Patient Witness

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____

Signature of Personal Representative **Date/Time**

_____ _____

Printed name of Patient Representative Relationship to patient or authority to act for patient

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Created: March 2009
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