LAKE REGIONAL HEALTH SYSTEM
54 HOSPITAL DRIVE, OSAGE BEACH, MO 65065

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Rvw. 8/14
Rev. 10/14

Fax: (573) 348-8223 (HIM) Phone: (573) 348-8729 (HIM) Other Fax: _____ Other Phone: _____

We are required by law to obtain your authorization to use or disclose your health information in certain circumstances.

You may refuse to sign this Authorization. You will not be refused health care treatment, payment for health care services, enrollment in a health plan or eligibility for health care benefits if you do not sign this Authorization.

Once this information is disclosed to the person or persons identified below, your information may be subject to redisclosure by that person or persons.

You may revoke this Authorization at any time by sending a written notification to the attention of the Privacy Officer at the address listed at the top of this form. Such revocation will not apply to information that we have already used or disclosed in reliance on this Authorization. Unless you revoke this Authorization in writing, this Authorization will expire:

☐ _____ days from the date this Authorization Form is signed; or
☐ Upon the expiration of the event for which this Authorization Form is requested.

You have the right to inspect and copy the information that may be used or disclosed pursuant to this Authorization. We may charge you a reasonable fee for copying and mailing this information. A copy of this Authorization will be provided to you after you sign it.

HEALTH INFORMATION TO BE USED OR DISCLOSED:

Patient Name: _____ Date of Birth: _____ SSN: _____

Complete Address & Telephone Number _____

_____

Date(s) of Treatment Requested _____

I request only the following information to be released/obtained:

☐ Designated Record Set ☐ Operative Report ☐ Mammograms ☐ EKG
☐ Emergency Report ☐ Pathology Report ☐ Cardiac Cath Lab Cine Film
☐ Discharge Summary ☐ Radiology Reports ☐ Cardiac Cath Lab Reports
☐ History & Physical ☐ Radiology CDs ☐ Photographs, videotape, Digital, or other images
☐ Laboratory (specify):_____
☐ Other (specify): _____
☐ Itemized Billing Statement

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

If my medical or billing record contains information about drug and/or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B and C testing and/or other sensitive information, I agree to its release. *Check One:* ☐ Yes ☐ No

If my medical or billing record contains information about HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. *Check One:* ☐ Yes ☐ No

_____ Patient will pick up _____ Mail _____ Fax to Doctor Only _____ Fax Number

PURPOSE OF THE USE OR DISCLOSURE OF HEALTH INFORMATION:

The information described above is being used / disclosed to _____

Address: _____ Phone: _____

for the following purpose: _____

Do you want PHI electronically? ☐ Yes ☐ No If yes, please provide valid email address_____
You will be directed to a secure website and given a generic password.

SIGNATURE OF PATIENT

I, _____ have read and understand the above information and authorize:

☐ LAKE REGIONAL HEALTH SYSTEM ☐ LAKE REGIONAL IMAGING PARTNERS, LLC ☐ Other_____
to use or disclose the information identified above to the persons and for the purpose described above.

_____
Signature of Patient or Legal Representative Date Time

_____ _____
Relationship to patient if signed by other than the patient Signature of Witness Date Time

(FF-00309)