Lincoln County Public Hospital District #3
AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION AND RECORDS

Patient Name:_____ Date of Birth ____/_____/_____
HEALTH CARE INFORMATION AND RECORDS TO BE **RELEASED TO**:

Name _____ Phone _____

Address _____ Fax _____

City _____State _____ Zip _____

(☐ Mailed, ☐Faxed, ☐Given to Patient, ☐Oth **OFFICE USE** *Records Released by* _____*Date*_____

TYPES OF INFORMATION TO BE RELEASED:

I permit Lincoln County Public Hospital District #3, herein referred to as "Provider," to release the following health care information to the Provider listed above. I understand that the Provider needs my written authorization to release any health care information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS) or psychiatric disorders/mental illness. Based on the box(es) I have checked below, the Provider may release all diagnostic, treatment information and records, except psychotherapy notes as defined by the Health Insurance Portability and Accountability Act of 1996, which requires a separate authorization.

☐ Discharge Summary
☐ EKG
☐ Emergency Room Record
☐ History & Physical
☐ Radiology
☐ Pathology Report
☐ Progress Notes
☐ Laboratory Results
☐ Operative/Procedure Notes
☐ Other_____

Date(s)/Range of Service(s): _____

PURPOSE FOR RELEASE AND HOW INFORMATION WILL BE USED:

☐ At the request of the Patient ☐ For coordination of care ☐ Legal Review/Proceedings
☐ Discuss Health Care & Billing Info with Family or Friend(s) named above with ☐ *No Expiration Date*
☐ Other _____

REVOCATION OF RELEASE:

I understand that I may change my mind and revoke this release at any time. I will do this by letting the Provider know of my decision. Any change will be effective five (5) business days receipt of written notice. I understand that some or all of this information may already have been shared and that the Provider will not be liable for any information already released.

RE-DISCLOSURE:

Information disclosed as a result of this authorization may be disclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

NO CONDITIONS:

This authorization is voluntary. We will not condition your receipt of treatment on giving this authorization.

TIME FRAME OF RELEASE:

Unless otherwise specified I revoke it, this release will remain valid for ninety (90) days from the date of my signature below.

CONSENT OF MINOR:

A minor patient's signature is required in order to release information concerning care for: 1) conditions relating to the minors sexuality including, but not limited to, contraception, pregnancy, and pregnancy termination, sterilization and sexually transmitted disease; 2) alcoholism or drug abuse; and 3) mental health conditions [Age fourteen(14) and above for drug and/or alcohol related information or information related to sexuality; age thirteen(13) and above for mental health information.]

***Signature** _____ Date _____

Print Name _____
FIRST MIDDLE INITIAL LAST

***If not the patient, I am the: ☐ Parent or ☐ Legal Guardian** ☐ Holder of Power of Attorney for Health Care**

****Attach a copy of legal documentation if you are the legal guardian or holder of a power of attorney for the patient.

Revised May 2019

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Purpose: This form authorizes Lincoln County Public Hospital District #3 (Lincoln Hospital) to use or disclose your protected health information for a particular purpose other than to carry out treatment, payment or healthcare operations. If this authorization is for psychotherapy notes, it may not be used as an authorization for any other type of protected health information.

The Individual confirming the authorization – I authorize the use and/or disclosure my protected health information as described below. I understand this authorization is voluntary and made to confirm my direction. I understand that Lincoln Hospital may not condition the provision of medical treatment upon my signing this authorization unless the provision of such treatment is for disclosure to a third party. I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

The Use and/or Disclosure Being Authorized - Specifically and meaningfully describe the protected health information you are authorizing Lincoln Hospital to use and/or disclose (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization) and the purpose of the use or disclosure.

ACCESS REQUEST

Purpose: This form is used for an individual's request and/or obtain copies of the individual's protected health information or records maintained in Lincoln Hospital's designated record sets or the designated record sets of a business associate of Lincoln Hospital.

Right to Inspect or Obtain Copy: You have the right to inspect and obtain a copy of your protected health information in designated record sets Lincoln Hospital, or its business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes Lincoln Hospital may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records.

Lincoln Hospital has the right to charge for the copies; the fees are $_____ per page to copy these records. If you want the copies mailed you will be required to pay for the postage and handling.

Lincoln Hospital must respond to an access request within 30 days of its receipt, unless the requested records are off-site. We then have 60 days to respond.

Extension of response date: We may take one 30-day extension of our response date by notifying the requester within the original 30 – 60 day response period of the reason for the extension and the date on which we will provide our response.

Laboratory Results - Requesting Laboratory results can be done for specific tests (Comprehensive Metabolic Profile/CMP, Lipid Profile, CBC, TSH, PSA, Glycohemoglobin, and Dilantin) and provided by;

1. Physician or provider order for the test, that also states, "Provide results to the patient when available," and
2. A completed REQUEST Form.