LAKESHORE community health care

MRN/Chart#:_____

1) _____
Name Address City State Zip

_____ ( ) _____
Date of Birth Daytime Phone Previous Name

2) AUTHORIZES TO RECEIVE: Please list one agency per form

_____
Name of Medical Provider/ Dental Provider/Facility/Other

_____
Address City State Zip

_____
Phone Number Fax Number

3) AUTHORIZES TO DISCLOSE:

_____
Name of Medical Provider/ Dental Provider/Facility/Other

_____
Address City State Zip

_____
Phone Number Fax Number

4) ☐ CHECK HERE IF AUTHORIZATION IS RECIPROCAL (Disclosing party and the recipients(s) may mutually exchange the information noted below)

5) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ (if left blank, information from the past two (2) years will be disclosed.)
month/year *month/year*

6) INFORMATION TO BE DISCLOSED: ☐ **Verbal** ☐ **Written**

☐ Alcohol/ Drug Abuse Assessment ☐ Discharge Instructions ☐ Discharge Summary ☐ History & Physical
☐ Identify and Presence in Treatment ☐ Initial Mental Health Assessment ☐ Lab Results ☐ Legal Status/Court Records
☐ Medications/Medication Profile ☐ Outpatient Mental Health/AODA Records ☐ Progress Notes/Update
☐ Psychiatric Evaluation ☐ Psychosocial Assessment ☐ Treatment Plans ☐ X-ray/EKG
☐ Billing records related to (specify):_____
☐ Other (specify):_____
_____

☐ **CHECK HERE IF YOU DO NOT WANT HIV TEST RESULTS (IF THEY EXISTED) TO BE DISCLOSED**

7) EXPIRATION: This Authorization is good until the following date/event:_____

8) PURPOSES: (check all that apply): ☐ Care Coordination ☐ Further Follow-up Care ☐ Insurance Eligibility/ Benefits
☐ Legal Investigation/Action ☐ Obtain Collateral Information ☐ Personal (at my request) ☐ Verify Compliance with Treatment
☐ Other:_____

9) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

10) SIGNATURE OF PATIENT:_____ **DATE:** _____

SIGNATURE OF LEGAL REPRESENTATIVE:_____ **DATE:**_____
If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority is: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of child.

For Office Use Only:

AUTHORIZATION FOR DISCLOSURE OF MEDICAL/MENTAL HEALTH/DENTAL AND/OR ALCOHOL/DRUG ABUSE INFORMATION
(Consent)