LAKESHORE community health care

MRN/Chart#: _____

_____

Name Address City State Zip

_____ ( ) _____

Date of Birth Daytime Phone Previous Name

AUTHORIZES TO RECEIVE: Please list one agency per form	**AUTHORIZES TO DISCLOSE:**
_____	_____
Name of Medical Provider/ Dental Provider/Facility/Other	Name of Medical Provider/ Dental Provider/Facility/Other
_____	_____
Address City State Zip	Address City State Zip
_____	_____
Phone Number Fax Number	Phone Number Fax Number
_____	_____
Email Address	Email Address

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

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*

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

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

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

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

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: _____

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.

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.