Lane Regional Medical Center

Care You Can Count On

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize ________________________________of Lane Regional Medical Center to use or disclose the following Protected Health Information (PHI) from the medical records of the patient listed below to:

Recipient's Name: ________________________________ Log# ________________________

Recipient's Address: ______________________________

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Patient's Name: ______________________________

Patient's DOB: ______________________________

Patient's SSN: ______________________________

Patient's Address: ______________________________

Patient's Number: ________________________

Please check the type of PHI to be released:

- ☐ Entire Medical Record
- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ Summary Sheet
- ☐ History & Physical
- ☐ Op Notes
- ☐ Consultation
- ☐ Itemized Bill
- ☐ Lab Reports
- ☐ X-Rays
- ☐ Progress Notes
- ☐ Doctor's Orders
- ☐ ER Report
- ☐ Other/Specify Below

Disclose the following PHI for treatment dates: ____

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The above information is disclosed for the following purposes: (Check All That Apply)

- ☐ Marketing (Reimbursement expected from recipient)
- ☐ Marketing (No Reimbursement Expected)
- ☐ Medical Care
- ☐ Legal
- ☐ Personal
- ☐ Insurance
- ☐ Other/Specify Below

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______ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug
Initials abuse, psychiatric, HIV, or genetic information.

This authorization shall expire upon this expiration date or event: ______________________________

If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the Privacy Officer at Lane Regional Medical Center. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the sole purpose of collecting information to provide to a third party or for research purposes, treatment may be denied if this authorization is not signed.

I have read the above and authorize the disclosure of Protected Health Information as stated.

Signature of Patient/Legal Representative: ________________________________ Date: ____________

If signed by a legal representative, describe this person's authority to act on behalf of the patient:

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LMH AUDHI