Lakeland Regional Health®

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Legal Name: _____ MRN: _____

Address: _____ Date of Birth: _____

_____ Last 4 of SSN: _____

Patient's Phone Number: _____

I authorize Lakeland Regional Health

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

☐ to disclose my PHI to ☐ to obtain my PHI from

Name: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

for the following dates of service: _____

☐ Paper ☐ Electronic ☐ Email address for electronic delivery: _____

The type of information to be used or disclosed is as follows (check appropriate boxes and include other information where indicated).

☐ Abstract (dictated reports, laboratory, cardiology, radiology)
☐ CD (radiology, echocardiogram or cath lab images)
☐ Emergency department record(s)
☐ History & physical
☐ Other _____
☐ Laboratory report(s)
☐ Operative report(s)
☐ Radiology report(s)
☐ Consultation report(s)
☐ Progress notes
☐ Pathology report(s)
☐ Billing record(s)
☐ Discharge summary
☐ EKGs

I understand that the protected health information specified above includes mental health, substance abuse (i.e., drugs, alcohol), HIV/AIDS status information unless redaction is requested. ☐ Redaction requested _____ (please initial)

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing. I understand that my revocation does not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
2. I understand that the information disclosed may be subject to re-disclosure and no longer protected by federal or state privacy laws.
3. I understand that I am signing this form voluntarily and I am signing this under my own free will. Lakeland Regional Health will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
4. I further agree to pay charges to provide the information requested per Florida Statute 395.3025 or Florida Administrative Code 64B8-10.003.
5. I understand that unless otherwise revoked, this authorization will remain valid for six (6) months from the date signed below.

Signature: _____ Date: _____

Patient or Authorized Person: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Personal Representative ☐ Power of Attorney

☐ Photo ID verified

Witness: _____ Date: _____

Released by: _____ Date: _____ # of Pages Copied:_____