

LANE PHYSICIAN GROUP
An Affiliate of Lane Regional Medical Center
AUTHORIZATION TO OBTAIN
PROTECTED HEALTH INFORMATION

I hereby authorize _____ to obtain from _____ at _____ the following Protected Health Information (PHI) from the medical records of the patient listed below.

Please fax or email to: _____

Patient's Name: _____
Patient's DOB: _____
Patient's SSN: _____
Patient's Address: _____

Disclose the following PHI for treatment dates: _____

Please check the type of PHI to be released:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Op Notes | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> X-Rays | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Doctor's Orders | <input type="checkbox"/> ER Report | <input type="checkbox"/> Other/Specify Below |

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

- | | | | | |
|--|--|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Marketing (Reimbursement expected from recipient) | <input type="checkbox"/> Marketing (No Reimbursement Expected) | | | |
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Legal | <input type="checkbox"/> Personal | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other/Specify Below |

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

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 or Legal Representative: _____ Date: _____

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