AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
HEALTH INFORMATION SERVICES DEPARTMENT

Patient Name: ___________________________________ DOB: ____________ SSN: _________________ MR#:________________

Release information to:____Patient phone number_________________________

Address: ____

Reason for Release: ❑ Insurance ❑ Legal Reasons ❑ Personal Reasons ❑ Workers Comp
❑ Disability Determination ❑ Continued Medical Care under Dr. _______________________
❑ Other Reasons _________________________________

Please initial the following:

____________________ I hereby authorize Lenoir Memorial Hospital to provide the above named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

MEDICAL DATA / INFORMATION

For the dates of ____
Please initial spaces beside documents you wish to release:

__________ Entire Medical Record
__________ Demographic Data (Face Sheet with Address, Phone, SSN)
__________ History and Physical Report
__________ Discharge Summary Report
__________ Consultation Report
__________ Operative/Procedure Records
__________ Ancillary Personnel Notes (check all those that apply)
___ Nursing ___ Social Services ___ Pharmacy ___ Dietary
__________ Emergency Room Records
__________ Daily Physician's Progress Notes
__________ Physician's Orders
__________ Laboratory/Pathology Reports
__________ Radiology Reports
__________ Cardiopulmonary Reports
__________ Diagnostic Images

The following items must be initialed to be included in this request for release of information:

____________________ HIV/Aids Related Information
____________________Mental Health Information
____________________ Drug & Alcohol treatment information

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving this information and would then no longer be protected by federal regulations.
- I understand that this authorization is revocable in writing at any time and that the revocation will be effective e3xcept to the extent that Lenoir Memorial Hospital has already taken action in reliance on my authorization.
- Unless revoked earlier, this authorization will remain in force for ninety (90) dates from the date of signature on this form. Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted without completion of the new authorization.

Note: there will be charge for a personal copy of your records. Healthport has been contracted to provide this service and will invoice you directly.

Signature of Patient: ____ Date: ___________________________

OR, if patient is unable to sign …

Signature of Authorized Representative: ____ Date: ___________________________

Relation to Patient: ❑ Mother ❑ Father ❑ Spouse ❑ Adult Child ❑ Adult Sibling ❑ Legal Guardian
❑ Executor of Estate ❑ HCPOA ❑ Other

Reason Patient Cannot Sign: ____

Signature of Witness: ____ Date: ___________________________

**** Authorizations not signed in the presence of a Lenoir Memorial Hospital employee must be notarized. ****

Signature of Witness/Notary: ____ My Commission Expires: ____________________

Sworn to and Subscribed before me on this, the _______ day of ____________________________ 20 __________.

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[Type text]

LMH: 2040
Date Created: 02/14

Department Use Only

ID Check: Drivers License _____ Other ID _____ Signature Comparison ______

Medical Record Number: ___________________________ FORMAT: _____ HARD COPY _____ELECTRONIC

Department Use Only

Entire _______ Lab _______EKG _______
DS _________ OP _______ IMM ________
HP _________ X-ray _____ Path ________
Other ______________________________

____
Employee Signature

____
DATE

Number of Pages __________

[Type text]

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