MEDICAL RECORD RELEASE

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name _____ Date of Birth _____ Medical Record # _____

Address _____ City, State, Zip _____ Phone # _____

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release My Health Information: _____

Address _____ City, State, Zip _____ Phone # _____

Agency or Individual(s) to Receive my Health Information: _____

Address _____ City, State, Zip _____ Phone # _____

Health Information that may be used/disclosed is limited to the following: ☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other (specify): _____

Sensitive Information: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

Health Information that may be used/disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____
From (date): _____ To (date): _____

Health Information to be released to the above name agency/individual is to be used/disclosed for the following purpose(s):
☐ Treatment/Consultation ☐ At request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other: _____

"Health Information identifies you (the patient) by name and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents, and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

If no specific date or event is noted below, this authorization will automatically expire 60 days after the date of signature. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made the disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization my result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY/INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative _____ Date/Time _____

Relationship to Patient/Authority to Act of Patient's Behalf _____ Date/Time _____

Witness Signature _____ Date/Time _____

Identity verified by: ☐ Photo ID ☐ Matching Signature ☐ Other, specify: _____

Phone: ▪ Fax:

MedStat
Lutheran Health Network