Lake Health District
Quality Care Close to Home

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Lake District Hospital| Ph: 541-947-2114 Ext. 369 | Fax: 541-947-3359
Lake Health Clinic | Ph: 541-947-3366 Ext. 172 | Fax: 541-947-4404
Lake Health Specialty Clinic| Ph: 541-947-7313 | Fax: 541-947-8109

Patient Name: _____ Date of Birth: _____

I authorize: _____ Ph: _____ Fax: _____

Address: _____ City: _____ ST: ____ Zip: _____

to release a copy of my protected health information for the following purpose below:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

Send Records to: _____

Initial below for the records to be released:

_____ Visit Summary
(**Includes:** Provider Notes, History & Physical, Operative Report, Discharge Summary, Diagnostics – i.e.: Radiology, Lab, Cardiac tests)

_____ Emergency Room Record
_____ Radiology Report(s)
_____ Itemized Billing Record(s)
_____ Lab Report(s)
_____ Cardiac Test(s)
_____ Other (specify): _____

_____ Records pertaining to specific Date of Service: _____

_____ Records pertaining to Worker's Compensation claim for injuries of (Date): _____

IMPORTANT: By initialing these items, you agree to release. ___ HIV/STI Test Results _____ Genetic Testing
___ Drug/Alcohol Notes/Visits _____ Mental Health Notes/Visits

Date: _____ Signature of Patient/Guardian: _____

Date: _____ Signature of Individual Authorized by Law: _____

If you wish for your protected health information to be provided to you in an unsecure electronic form, you must initial here: ____

I *authorize* my medical records to be sent to this *Email Address*: _____

IMPORTANT By initialing, I understand that the unencrypted email is not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any patient rights that I may have against Lake District Hospital, Lake Health Clinic and/or Lake Specialty, any affiliated organization, or physician, or the suppliers for any compromised information due to the technical failures and/or unintended break of confidentiality.

50 pages or more, will be mailed to the address provide.

For LHD Use Only: Date Completed: _____
Completed by: _____
Provider: _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will **expire 180 days** from the **date of signing** or **shall remain in effect for the period reasonable needed to complete the request**. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.