Lake Health District
Quality Care Close to Home

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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name (print): _____ Date of Birth: _____
Address: _____ City, State, Zip: _____
Telephone Number: _____ Social Security Number (Last 4 digits) XXXX_____

The undersigned hereby authorizes and requests:

☐ **Lake District Hospital** ☐ **Lake Health Clinic** ☐ **Lake Health Specialty Clinic**

Director of Medical Records and/or their designee to disclose and furnish this requested information to the person/facility below. The potential for this information to be redisclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of person/facility to be released to: _____ **Telephone:** _____
Address (City/State/Zip Code): _____ **Fax Number:** _____

Dates of treatment/service to be released: Purpose for which this information is to be released:
☐ Continuity of Care ☐ Personal Use ☐ Attorney/Legal Case ☐ Disability ☐ Insurance
☐ Other (specify): _____

INFORMATION TO BE RELEASED: (Check all that apply)
☐ Abstract (Discharge Summary, Operative Report, History & Physical, Radiology Written Report, Lab Results, and Consultations, if applicable)
☐ General Medical Record (Abstract information above and i.e., orders, notes and interdisciplinary care records filed to date)
☐ Lab Results ☐ Outpatient Records ☐ Emergency Room Record ☐ Cardiac Cath Report
☐ Immunization Record ☐ Operative Report ☐ Billing Report ☐ Radiology Written Report
☐ Radiology Films/Digital Images and Written Report ☐ Inpatient Records
☐ Other (Specify): _____

MY HIGHLY CONFIDENTIAL INFORMATION: *By initialing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated for the purposes indicated above.*

_____ INITIAL Abortion referral/services _____ INITIAL Gender affirming referral/services _____ INITIAL Patient Education _____ INITIAL Primary Care

_____ INITIAL Genetic testing _____ INITIAL Sex Reassignment Surgery Referral/services _____ INITIAL Behavioral Health referral/services

_____ INITIAL Birth control (Emergency contraception (Morning-After Pill), reproductive sterilization referral/services)

_____ INITIAL Men's Health referral/services (Birth control, fertility, prostate exams, Reproductive Cancer Screenings/Treatment, Sexual Dysfunction, STDs, Surgeries/Diseases involving male anatomy).

_____ INITIAL Communicable disease, (including sexually transmitted diseases) diagnoses, testing, lab results, treatment, vaccines referral/services.

_____ INITIAL Women's Health referral/services (Birth control, fertility, mammography, menopause/menstruation, Pelvic exams, Pregnancy Testing and related services, Reproductive Cancer Screenings/Treatment, STDs, and Surgeries/Diseases involving female anatomy

_____ INITIAL HIV and AIDS testing, diagnosis, treatment, Referral/services (including the fact that an HIV test was ordered, performed, or reported, regardless of whether the results of such tests were positive or negative)

_____ INITIAL Alcohol/drug abuse or addiction diagnosis/treatment

_____ INITIAL Child abuse and neglect* _____ INITIAL Domestic abuse by an adult* _____ INITIAL Sexual assault*

**** Such cases do not preclude mandatory reporting requirements by Health Care Providers and clinical personnel. Please ask your nurse or provider for further information.***

_____ INITIAL ***Note: Any correspondence sent via the US Postal Service is considered unsecure. Lake Health District will not be responsible for the security of such transfers once it has left the records custodians possession.***

_____ INITIAL ***I wish for my protected health information to be provided via US Postal Service.*** _____ INITIAL ***CD ROM***

_____ INITIAL ***I wish for my protected health information to be provided via unsecured email service to the following email address:*** _____

IMPORTANT *By initialing, I understand that unencrypted communications are not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive them 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.*

You must acknowledge you are authorizing indicated records by furnishing your written signature here: _____

Lake Health District is an Equal Opportunity Employer and Provider

Any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for which it is given. You have the right to revoke this authorization except that such revocation will not apply in any uses and disclosures of your information that are described in the above indicated facility Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted.
I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the consents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form. To revoke this information, write to the Director of Medical Records, Lake Health District, 700 South J Street, Lakeview Oregon, 97630. Include a copy of this authorization with your correspondence.

Patient/Representative Signature: _____ Date: _____

State your relationship to the patient if the patient is unable to sign or the authority you have to act on behalf of the patient. You must be able to furnish proof of relationship or authority to act for this patient: _____

If no authority to act on behalf of the patient is present and the patient is unable to sign, the patient shall mark this release with an "X" and in the presence of two (2) witnesses with their dated signatures below:

Witness Signature: _____ Date _____

Witness Signature: _____ Date _____

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