LAKESHORE
community health care

MRN/Chart#:________________

1) ____

Name | Address | City | State | Zip

( )
____

Date of Birth | Daytime Phone | Previous Name

2) AUTHORIZES TO RECEIVE: Please list one agency per form

____
Name of Medical Provider/ Dental Provider/Facility/Other

____
Address | City | State | Zip

____
Phone Number | Fax Number

3) AUTHORIZES TO DISCLOSE:

____
Name of Medical Provider/ Dental Provider/Facility/Other

____
Address | City | State | Zip

____
Phone Number | Fax Number

4) ☐ CHECK HERE IF AUTHORIZATION IS RECIPROCAL (Disclosing party and the recipients(s) may mutually exchange the information noted below)

5) DATE(S) OF INFORMATION TO BE DISCLOSED: From _________ to _________ (if left blank, information from the past two (2) years will be disclosed.)
month/year *month/year*

6) INFORMATION TO BE DISCLOSED: ☐ **Verbal** ☐ **Written**

☐ Alcohol/ Drug Abuse Assessment	☐ Discharge Instructions	☐ Discharge Summary	☐ History & Physical
☐ Identify and Presence in Treatment	☐ Initial Mental Health Assessment	☐ Lab Results	☐ Legal Status/Court Records
☐ Medications/Medication Profile	☐ Outpatient Mental Health/AODA Records		☐ Progress Notes/Update
☐ Psychiatric Evaluation	☐ Psychosocial Assessment	☐ Treatment Plans	☐ X-ray/EKG

☐ Billing records related to (specify):______________________________

☐ Other (specify):______________________________

____

☐ **CHECK HERE IF YOU DO NOT WANT HIV TEST RESULTS (IF THEY EXISTED) TO BE DISCLOSED**

7) EXPIRATION: This Authorization is good until the following date/event:______________________________

8) PURPOSES: (check all that apply): ☐ Care Coordination ☐ Further Follow-up Care ☐ Insurance Eligibility/ Benefits
☐ Legal Investigation/Action ☐ Obtain Collateral Information ☐ Personal (at my request) ☐ Verify Compliance with Treatment
☐ Other:______________________________

9) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

10) SIGNATURE OF PATIENT:______________________________**DATE:** ______________

SIGNATURE OF LEGAL REPRESENTATIVE:______________________________**DATE:**______________

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority is: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of child.

For Office Use Only:

AUTHORIZATION FOR DISCLOSURE OF MEDICAL/MENTAL HEALTH/DENTAL AND/OR ALCOHOL/DRUG ABUSE INFORMATION

(Consent)