LAWRENCE HOSPITAL CENTER

AUTHORIZATION FORM FOR RELEASE OF PATIENT INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to redisclosure and may no longer be protected by the federal privacy regulations.

Patient Name:_____ MR#: _____
Address:_____ DOB: _____
_____ Ph #: _____

Persons/organizations authorized to use or disclose my information:	Persons/organizations who may receive my information (address &ph #)
_____	_____
_____	_____
_____	_____

Specific description of the information to be used or disclosed (including date(s)):
_____
_____
_____
_____

Description of each purpose of the use or disclosure of my patient information: (***Note:*** **If the release of information is requested by the patient, please insert "at the request of the patient" here if the patient does not provide a statement of purpose).**
_____
_____
_____

Section B: The patient or the patient's representative must read and initial the following statements:

_____ 1. I understand that this authorization is valid for 10 years or as otherwise specified. Initials

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_____ Initials

2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

_____ Initials

3. I understand that I will get a copy of this form after I sign it.

_____ Initials

4. I understand that I may revoke this authorization at any time by notifying the Hospital in writing, but if I do, the revocation will not have any effect on actions the Hospital has already taken in reliance on this authorization.

_____ _____

Signature of patient or patient's representative **Date**
(*Note:* This form MUST be completed before signing.)

If this authorization is signed by a patient's representative, please complete the following:

_____

Print name of patient's representative:

_____

Relationship to the patient:

Describe the representative's authority to act for the patient:

_____

_____

_____

Revised 4/03