LANCASTER FAMILY MEDICINE ASSOCIATES, P.C.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:_____ Maiden Name:_____

Date of Birth: _____ Social Security Number: _____ Phone Number _____

Address: _____

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

OBTAIN FROM what organization	**RELEASE TO** what organization
_____	_____
_____ Address	_____ Address

Date(s) of Service:_____

☐ **COMPLETE MEDICAL RECORD**
History & Physical, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, X-ray and imaging reports etc.
☐ **INDIVIDUAL RESULTS LISTED ABOVE (please specify):**_____
☐ **IMMUNIZATION RECORD**
☐ Other (Please specify):_____

For the purpose of:

☐ Changing Physicians ☐ Insurance Eligibility/Benefits ☐ Personal
☐ Further Medical Care ☐ Legal Investigation/Action
☐ Other (please specify): _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.
  State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):
  Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No Dates: _____
  HIV Testing and Results ☐ Yes ☐ No Dates: _____
  Mental Health or Psychotherapy Records ☐ Yes ☐ No Dates: _____
- I understand that if the use/disclosure of these records is for my own use, I will be charged a fee per page based on the current PA Dept. of Health fee schedule.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.
- I understand that I may revoke this authorization at any time by notifying LFMA in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by LFMA before receiving my revocation. **This authorization will expire 90 days from this signature date, unless revoked sooner.**

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient (please print)

_____ _____
Signature of Witness Date

If signed by person other than the patient, state relationship and authority to do so:

Patient is: ☐Minor ☐Incompetent ☐Disabled ☐Deceased

Legal Authority: ☐Custodial Parent ☐Legal Guardian ☐Executor of Estate or Deceased
☐Power of Attorney for Healthcare ☐ Authorized Legal Representative