

Authorization for Release of Information

Patient Legal Name: _____
(Last) (First) M.I. Preferred Name (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Patient's Address: _____
(po box # or street, city, state, zip code)

This information is to be used for purpose of: Personal use Continuing care Legal Disability Workers Comp
 Insurance Eligibility/Benefits Social Security Claim Veterans Benefits Other _____

Release information from my medical record to:

Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Delivery Method: (Choose one only)

MyChart patient portal (Must have active account. To activate your account go to mychart.ynhhs.com)

Mail Fax (Please enter the fax number): _____

Secure Email: _____ Pick Up/Hand Carry Format: CD-ROM

Information to be sent:

Date of Service(s): _____ **Or Date Range From:** _____ **To:** _____

Medical Information Requested:

Hospital Admission Abstract (Includes: History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

| | | | |
|---|---|--|--|
| <input type="checkbox"/> Outpatient Visit Notes | <input type="checkbox"/> History & Physical Exam/HP | <input type="checkbox"/> Stress Test | <input type="checkbox"/> Consult Report |
| <input type="checkbox"/> Discharge Summary/DS | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Echocardiogram/EKG | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Emergency Visits/ED | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Pulmonary Function Test | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> PT/OT/Speech Notes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Complete Medical Record (Excludes data collection flowsheets unless specifically requested). | | | <input type="checkbox"/> Include Flowsheets |

Items requested below will be sent separate from medical records:

Radiology Images: Please specify date and type of test: _____

Itemized Bill: Please specify date of service: _____



SENSITIVE INFORMATION: All information selected on page 1 will be disclosed with this authorization unless specifically requested to be excluded as indicated below. Please do NOT include the following information:

- HIV Behavioral Health/Psychiatric Substance Abuse (which includes Alcohol & Drug Abuse)
 Termination of Pregnancy Sexually Transmitted Disease Genetic Testing
 Other: _____

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing Lawrence + Memorial Hospital Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by Lawrence + Memorial Hospital is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Behavioral Health, Drug/Alcohol information is included, the minor must sign as described above.

***** Medical records containing protected information under applicable federal or state laws must also be authorized by a minor when age 13 or older (e.g. HIV, substance abuse (including alcohol & drug abuse), termination of pregnancy, and/or sexually transmitted disease). For behavioral health, the patient if a minor age 16 or older is also required to authorize release of medical records.**

Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.

Mailing Address: Lawrence + Memorial Hospital
Health Information Management
Release of Information Services
365 Montauk Avenue
New London, CT 06320

Fax Number: 860-444-3760

Email to: releaseofinfo@lmhosp.org

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 860-444-3704.

Printed Name: _____

Date: _____

Signature of Patient or Authorized Representative

***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

- Self Parent Legal Guardian Executor/Administrator of Estate Healthcare Representative Conservator
 Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)***

Signature of Minor (when applicable)***

Date