LRGHealthcare
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record No._____

Address: _____ Date of Birth: _____

_____ Phone Number: _____

[ ] I hereby authorize LRGHealthcare to disclose any and all of my health information to:

_____

[ ] I hereby authorize _____
To disclose any and all of my health information to LRGHealthcare.

1.Information to be disclosed:
_____

_____

_____

For the purpose of _____

2.To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, LRGHealthcare will release such information about me if it exists.

[ ] HIV/AIDS Infection
[ ] Genetic Information
[ ] Mental Health
[ ] Sexually Transmitted Diseases
[ ] Treatment for Alcohol and/or Drug Abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. I understand that the recipient of this information may redisclose this information and the information may no longer be protected by Federal or State confidentiality laws.

5. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying LRGHealthcare. I understand that any previously disclosed information would not be subject to my revocation request.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here.
_____

_____

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

5/2013