Request & Authorization for Use/Disclosure of Protected Health Information

Patient Information (PLEASE PRINT)

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

READ THE FOLLOWING CAREFULLY:

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information requested in this authorization. Unless revoked earlier, this authorization will expire one year from the date of signature or shall remain in effect for the period reasonable to complete the request. The patient or the patients authorized representative is entitled to request a copy of this form.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by law.

*****THERE MAY BE A CHARGE FOR THE REPRODUCTION OF MEDICAL RECORDS.*****

The reproduction of my Protected Health Information should be provided in the following manner (check all that applies):

☐ Print on paper for pick up by authorized recipient: _____ (Must show ID to pick up)

☐ Mail to: _____

☐ Fax to (if other than Lexington Family Physicians): _____

I authorize (Name of Practice): _____

Practice Address: _____ State: _____ Zip: _____

Phone #: _____ Fax#: _____

to disclose the following information to: **Lexington Family Physicians, P.A.**
102 West Medical Park Drive, Lexington, NC 27292
Phone: 336.249.3329 Fax: 336.249.3795

The information is to be disclosed for the purpose of: ☐ Transfer of Care ☐ Legal Representation ☐ Patient Request

☐ Other (specify): _____

Information to be disclosed (check all that apply):

☐ Hospital Discharge Summary ☐ Office Progress Notes (Well Child Checks / Adult Physicals / Immunizations) ☐ Echocardiogram

☐ Most Recent Lab/Pathology Test Results ☐ X-ray Reports / Diagnostic Reports (ie: Mammogram, Colonoscopy)

☐ Other (specify): _____

_____ _____
Signature of Patient Date

_____ _____
Signature of: ☐ Parent ☐ Guardian ☐ Authorized Representative (attach copy of legal documents) Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

OFFICE USE ONLY:

DATE PROCESSED: _____ **NUMBER OF PAGES:** _____ **INITIALS:** _____ **CHARGE: $** _____

CIRCLE ONE: MAILED FAXED PICKED UP **PATIENT NOTIFIED OF CHARGE? YES NO**