**Lawrence + Memorial Hospital** YaleNewHaven**Health**

## Authorization for Access/Release of Information

**Patient Name:** _____ _____ _____ _____
(Last) (First) (Middle Initial) (Maiden/Other Name)

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

_____

**Complete Address (street or box#, city, state, zip)**

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

**I hereby authorize Lawrence + Memorial Hospital to:**

☐ **RELEASE information from my medical record TO:** ☐ **OBTAIN information FROM:**

**Name:** _____ **Phone:** _____

**Address:** _____ **City/State:** _____ **Zip Code:** _____

**Fax** (optional): _____ **Email** (optional): _____

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**Method of Disclosure:** ☐ MyChart (Must have active account) ☐ Mail ☐ Fax ☐ Secure Email
☐ Pick-up Please indicate how you would like to be contacted when ready for pick-up: _____ Format: ☐ CD-ROM

**Visit Type:** ☐ Admission ☐ Outpatient Surgery ☐ Emergency Dept. Visit ☐ Physician Office/Clinic ☐ Other _____

**Date(s) of Service:** _____

**Medical Information Requested:**

☐ Abstract of Medical Record (History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

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|---|---|---|---|
| ☐ History & Physical Exam/HP | ☐ Lab Results | ☐ Stress Test | ☐ Consult Report |
| ☐ Discharge Summary/DS | ☐ Radiology Report | ☐ Echocardiogram/EKG | ☐ Clinic/Office Notes |
| ☐ Emergency Visits/ED | ☐ Pathology Report | ☐ Pulmonary Function Test | ☐ Medication List |
| ☐ Operative/Procedure Report | ☐ Immunization Record | ☐ PT/OT/Speech Notes | ☐ Other _____ |

☐ Complete Medical Record *(Includes all of the above, plus nursing notes, ancillary notes, and consents. Excludes nursing flowsheets unless specifically requested)*.

☐ Itemized Bill ☐ Radiology Image(s): _____
*Please note date and type*

*Reasonable cost-based fees apply.*

*****HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION** contained within the medical records indicated above will be released through this authorization unless otherwise indicated below. **(Medical records containing any of the protected information below must also be signed by the patient if a minor age 13 or older, with the exception of Behavioral Health, which also requires authorization by the patient if a minor age 16 or older.)*****

**Indicate which you do NOT want released with your initials:**

**____ HIV ____ Substance Abuse (which includes Alcohol & Drug Abuse) ____ Pregnancy Test ____ Genetic Testing**

**____ Behavioral Health/Psychiatric ____ Sexually Transmitted Disease ____ Other (please list)** _____

**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 for a patient age 13 or older, the minor must sign as described above.

**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: _____

Print Form and Sign Here

_____
**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 |
|---|---|---|
| | | |