LINCOLN
INTERNAL MEDICINE

Authorization to Use or Disclose Health Information

From: _____ **To:** _____

_____ _____

_____ _____

Phone: _____ **Phone:** _____

Fax: _____ **Fax:** _____

REGARDING:
Patient Name: _____ **DOB:** _____

If you are a **patient** requesting your records to be **sent to you**, please choose ONE of the following options:

_____ I would like my records **e-mailed** to me. I have provided my e-mail address below. **Electronic records will be deleted from the portal 30 days after the email notification.**

Email Address for Electronic Delivery from HealthPort:

_____ I would like my records **mailed** to me at the address listed above.

Please disclose the following information from my records for:
Dates___/___/___ to ___/___/___

___ History and Physical
___ Physician Progress Notes
___ X-Ray Reports
___ Laboratory Reports
___ Medication List
___ Only records generated by this office (not including records from other sources)
___ All Medical Records at this facility for the **Last 2 years only**. (Excluding actual X-Ray films, unless specified.)
___ Other (specify)_____

The information will be used for the purpose of:

_____ The patient's use
_____ Changing Physicians
_____ Consultation/Second Opinion
_____ Insurance
_____ Social Security Disability Appeal (**Note:** Initial Social Security disability requests are sent by the Social Security office.)
_____ Legal Proceedings (we request the reason for proceeding)

_____

_____ Other (Specify Use) _____

OVER →

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 for alcohol or drug abuse. I am authorizing the release of the following information:

Sexually transmitted disease	yes____	no____	N/A____
Acquired Immunodeficiency Syndrome (AIDS)	yes____	no____	N/A____
Human Immunodeficiency Virus (HIV)	yes____	no____	N/A____
Behavioral or Mental Health services	yes____	no____	N/A____
Treatment for drug or Alcohol abuse	yes____	no____	N/A____

I understand that a photocopy or a faxed copy of this authorization will be considered as valid as the original. All requests to inspect, copy or disclose your Protected Health Information will be reviewed by the Physician and approved or possibly denied. We may legally be prohibited from making certain information available to patients or patient representatives, including:

- Psychotherapy Notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or to another person
- Information that was obtained under a promise of confidentiality

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released or used in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I understand I may inspect the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that the copies or electronic transmissions to me contain sensitive information about me. Lincoln Internal Medicine Associates shall not be liable for any damages whatsoever arising from any disclosure, attempted disclosure, use or attempted use of any of the information contained in the copied records or electronic file once it has been release to you or the persons or entity noted in your request.

_____ _____

Signature of Patient or Legal Representative Date

_____

If signed by the Personal Representative, note relationship to patient

If information is being picked up by someone other than patient, please state below:

_____

Two forms of I.D., one photo, will be required to pick up records.

Witnessed/Approved by: _____

NOTICE: LIMA uses HealthPort copy service for our records requests. There may be a fee for records that are copied and mailed or electronically sent to the patient. The standard fee is 50¢ per page. The patient will also be responsible for Shipping & Postage fees (if applicable). Invoices are included with the paper or electronic records. For those who are picking up their records, it is due at pick up.