

Authorization for Release of Protected Health Information

Patient's full name: _____ MRN _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

 Purpose of release: Request of individual Transfer of care Other _____

I authorize _____ to release my health information to: _____ Recipient's Address: _____ City: _____ State: _____ ZIP: _____ *FAX:() _____	Method of Receiving: <input type="checkbox"/> Mail Record <input type="checkbox"/> I will pick up <input type="checkbox"/> FAX (*providers only)
---	---

Information to be Released: (Please check all that apply)

 Provider(s): _____ All Lexington Clinic providers
 Include Lexington Clinic Associated Practices:

- Commonwealth Urology Providers Dr. Patrick Leung
- Records covering period of time: _____ to _____ All dates of treatment
- Records regarding treatment for the following condition(s) or injury(ies): _____
- Ambulatory Surgery Center Records - (Check here if requesting Operative Report only)
- Other _____
- Any and all medical records in the possession of Lexington Clinic including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)

1. I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Director of Health Information at the address noted at the top of this form. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
3. I understand that I do not have to sign this authorization and that Lexington Clinic may not condition my treatment or payment on whether I sign this authorization.
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.
5. I understand that this authorization expires one (1) year from the date of signature unless a specific date or event is listed: _____
6. I understand that I will receive a copy of this authorization and that this request must be filled out in its entirety to ensure timely release of my information.

Signature of Patient or Authorized Person	Date	Contact Telephone Number
---	------	--------------------------

 Witness

Authorized Person's Relationship	Reason Patient is Unable to Sign
----------------------------------	----------------------------------

ALL AUTHORIZATIONS MUST BE MAILED TO ADDRESS AT TOP OF THIS FORM.
WE CAN ACCEPT FAXED REQUESTS FROM HEALTHCARE PROVIDERS ONLY.