LEBANON VALLEY FAMILY MEDICINE, INC.

1400 S. Forge Road, Suite 1, Palmyra, PA 17078 •Phone: 717-838-1301 • Fax: 717-838-5811
10484 Jonestown Road, Annville, PA 17003 • Phone: 717-865-6647 • Fax: 717-865-0324

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

(Copying fees may be charged. Fee schedule provided on reverse side of this form for your convenience.)

Name of Patient_____Name of Parent/Guardian if a Minor_____
Address_____Sex M or F
Date of birth ____/____/____ Home Phone# ( )_____Cell Phone# ( )_____

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED. *THE INFORMATION BEING DISCLOSED MAY INCLUDE* ***HIV/AIDS, DRUG/ALCOHOL ABUSE, SEXUAL/PHYSICAL ABUSE, & MENTAL HEALTH ILLNESS DATA.***

I HEREBY AUTHORIZE LEBANON VALLEY FAMILY MEDICINE, INC. TO
A. RELEASE TO OR B. RECEIVE FROM
(Circle one)

_____ _____ _____
(Name of authorized person, agency, institution, or other) (Phone#) (Fax#)

_____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Purpose of the Use/Disclosure: ☐ PCP ☐ Referral ☐ Insurance ☐ Moving
☐ Transfer of Care ☐ Changing of physicians ☐ Personal Use ☐ Other_____

Type of information to be disclosed consists of:
☐ Complete record (last 2 years including all immunization records, most recent EKG, most recent laboratory studies and mammogram and pap smear if applicable.)
☐ Other (please specify)_____

The information released shall include documentation from the treatment or examination rendered to me during the time period of:

_____thru_____
Date Date

****ATTENTION PHYSICIANS RELEASING RECORDS TO LEBANON VALLEY FAMILY MEDICINE**: If you are providing records on a disk rather than on paper, we ask that you kindly separate your files into these categories: Progress notes, immunizations, labs, x-rays, ekgs, hospitalizations, letters/reports, and miscellaneous.
**** PLEASE DO NOT FAX RECORDS UNLESS REQUEST IS URGENT.**

I understand that the individual I authorize to receive my medical information may not need to follow the same stringent privacy standards as Lebanon Valley Family Medicine, Inc. I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand this authorization may be revoked by me, through written notification, at any time, except for any action which has already been taken.

The requester of this information may not condition treatment or coverage on the patient or person providing the authorization.

I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated and herein. This authorization shall remain in effect and valid for 60 days.

_____ _____
Patient Signature (or legal representative) Date

_____
Relationship if signed by other than Patient

_____
Witness – **MUST BE SIGNED (unless mailed)**