Lakeside Medical Center
Health Care District Palm Beach County

Authorization for Use and Disclosure of Protected Health Information (PHI)

I. I hereby authorize _____ to disclose the following information from the health records of:

Member/Patient's Name	Member/Patient ID Number	Date of Birth	Telephone Number

Street Address	Apt. #	City, State, Zip Code

Covering the period(s) of healthcare:

From (date)	To (date)
From (date)	To (date)

II. Please check information to be disclosed:

____ Complete Health Record ____ Laboratory Tests ____ Other: _____
____ H&P ____ Photos, Tapes, Digital Pictures ____ Consultation Reports
____ Radiology Reports ____ Discharge Summary ____ Progress Notes
____ Radiology Films/CDs – list the exam(s) needed: _____ (MRIs and CT scans will be on a CD)
List Physician that needs films being requested: _____

III. Special Release for Sensitive Information or Tests related to: (Initial each line)

____ Substance Abuse (including alcohol and drug abuse)
____ Mental Health
____ Psychotherapy Notes
____ HIV or AIDS information
____ Sexually Transmitted Diseases
____ Tuberculosis, Communicable Diseases

IV. This information is to be disclosed to: **LAKESIDE MEDICAL CENTER**
for the purpose of: _____

V. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the Following date, event, or condition:

_____
Date, Event or Condition

NOTE: To revoke this authorization, the member must complete the Revocation of Authorization form.

VI. I understand that eligibility for District programs and payment of health claims may be affected if I do not sign this authorization.

VII. I understand that once the information has been disclosed, it may be re-disclosed by the recipient. This re-disclosure will not be subject to the Privacy Policies of the Health Care District of Palm Beach County.

VIII. The Health Care District, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative	Date
Signature of Witness	Date

Explanation of Personal Representative's Authority to Act for Patient

Copies Prepared By	Date

Org: 05/05/14
Rev: 02/10/15; 04/06/15