



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
HEALTH INFORMATION SERVICES DEPARTMENT

Patient Name: _____ DOB: _____ SSN: _____ MR#: _____

Release information to: _____ Patient phone number _____

Address: _____

Reason for Release: [] Insurance [] Legal Reasons [] Personal Reasons [] Workers Comp
[] Disability Determination [] Continued Medical Care under Dr. _____
[] Other Reasons _____

Please initial the following:

I hereby authorize Lenoir Memorial Hospital to provide the above named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

MEDICAL DATA / INFORMATION

For the dates of _____

Please initial spaces beside documents you wish to release:

- Entire Medical Record Emergency Room Records
Demographic Data (Face Sheet with Address, Phone, SSN) Daily Physician's Progress Notes
History and Physical Report Physician's Orders
Discharge Summary Report Laboratory/Pathology Reports
Consultation Report Radiology Reports
Operative/Procedure Records Cardiopulmonary Reports
Ancillary Personnel Notes (check all those that apply) Diagnostic Images
Nursing Social Services Pharmacy Dietary

The following items must be initialed to be included in this request for release of information:

- HIV/Aids Related Information Mental Health Information
Drug & Alcohol treatment information

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving this information and would then no longer be protected by federal regulations.
I understand that this authorization is revocable in writing at any time and that the revocation will be effective except to the extent that Lenoir Memorial Hospital has already taken action in reliance on my authorization.
Unless revoked earlier, this authorization will remain in force for ninety (90) dates from the date of signature on this form. Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted without completion of the new authorization.

Note: there will be charge for a personal copy of your records. Healthport has been contracted to provide this service and will invoice you directly.

Signature of Patient: _____ Date: _____

OR, if patient is unable to sign ...

Signature of Authorized Representative: _____ Date: _____

Relation to Patient: [] Mother [] Father [] Spouse [] Adult Child [] Adult Sibling [] Legal Guardian
[] Executor of Estate [] HCPOA [] Other

Reason Patient Cannot Sign: _____

Signature of Witness: _____ Date: _____

**** Authorizations not signed in the presence of a Lenoir Memorial Hospital employee must be notarized. ****

Signature of Witness/Notary: _____ My Commission Expires: _____
Sworn to and Subscribed before me on this, the _____ day of _____ 20_____.

100 Airport Road P.O. Box 1678 Kinston, North Carolina 28503-1678 P: 252-522-7117 www.lenoirmemorial.org

[Type text]



LMH: 2040
Date Created: 02/14

* A U T H O R I Z A T I O N *

Department Use Only

ID Check: Drivers License _____ Other ID _____ Signature Comparison _____

Medical Record Number: _____ FORMAT: _____ HARD COPY _____ ELECTRONIC

Department Use Only

Entire _____ Lab _____ EKG _____
DS _____ OP _____ IMM _____
HP _____ X-ray _____ Path _____
Other _____

Employee Signature

DATE

Number of Pages _____

[Type text]



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