Patient Label

LAKE HEALTH
TRIPOINT / WEST / BEACHWOOD MEDICAL CENTER
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Part A:

☐ **Lake Health Diagnostic Centers** ☐ **Lake Health Sleep Center** ☐ **TriPoint Medical Center**
☐ **Lake Health Mentor Wellness Campus** ☐ **Madison ED** ☐ **West Medical Center**
☐ **Lake Health Physician Group** ☐ **Mentor Physical Therapy** ☐ **Beachwood Medical Center**

Urgent Care Centers:
☐ **Chardon** ☐ **Willowick**
☐ **Mentor**

Name of Patient: _____
Last First Maiden / AKA

Address: _____

Date of Birth: _____ Home Phone: _____ MR #: _____

Email Address: _____

INFORMATION TO BE:

☐ Released to: _____ ☐ Obtained from: _____

I hereby authorize Lake Health (LH) / Lake Health Physician Group (LHPG) / Beachwood Medical Center (BMC) to release to/or obtain from the following facility, the information as specified below:

Facility/Name: _____
Phone #: _____ Fax #: _____
Address: _____
Date(s) of Treatment: _____
Reason for Treatment: _____

INFORMATION TO BE RELEASED / OBTAINED: Pertinent Summary (Includes all * items):

☐ Demographic / Facesheet ☐ Pathology Report * ☐ Radiology Report * ☐ Drug / Alcohol Info
☐ History & Physical * ☐ Consultation Report * ☐ Radiology Films ☐ EKG Report *
☐ ER Report * ☐ Entire Record ☐ Lab Reports * ☐ Cardiac Cath Report *
☐ Discharge Summary * ☐ Physical Therapy ☐ Psychiatric Info ☐ HIV / AIDS Info
☐ Operative Note * ☐ Other: _____

PURPOSE OF DISCLOSURE: ☐ Continued Treatment ☐ Personal Use ☐ Legal ☐ Other Specific Use _____

To be completed by the Organization if this authorization is for marketing, fundraising, research, or sale of Protected Health Information:
The organization will receive compensation in exchange for using or disclosing the health information as described above: ☐ YES ☐ NO

Upon admission as an inpatient or to an LHPG office practice, you were asked to sign a Consent for Treatment in which you designated that Lake Health and/or Beachwood Medical Center could utilize your health information for the purpose of treatment, payment, and other health care operations as defined by law. The above information you have requested to be disclosed requires you to sign an authorization because it is being released to a third party entity outside of Lake Health and/or Beachwood Medical Center.

The consent to disclose information may be revoked by you in writing at any time - except those disclosures, made in good faith that have already occurred. This consent expires one year (1) from the date of signature and applies to all services provided and protected health information created by Lake Health and/or Beachwood Medical Center prior to the date of this signature.

I certify that this Authorization has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I understand that redisclosure of my medical records by those receiving the above-authorized information may be accomplished without further written authorization and may no longer be protected. I attest that if such redisclosure is made, I will not hold Lake Health or Beachwood Medical Center responsible.

X _____
Signature of Patient/Parent/Patient Representative/Physician/Other as Allowable by Law

_____ _____ _____
Relationship to Patient ☐ Patient Unable to Sign Date

If signature is other than patient's signature, a copy of all legal documents verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care.) For a deceased patient: A death certificate coupled with executor of administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

Part B: **LH / BMC USE ONLY**

Pulled and Verified by: _____ Date: _____
Verify Photo ID by: _____ Date: _____
Method of Disbursement: ☐ Mail ☐ In-person ☐ Faxed ☐ Electronic Disclosure ☐ Other: _____
Forms of Records: ☐ Paper _____ # of pages copied _____ Cost ☐ Electronic # Pages _____ , Cost _____ (Retrieval/Media Fee)
Films returned and verified by: _____ Date: _____
☐ No disclosure made (see Part C).

EX4846

Copies of Medical Records are NOT to be emailed directly to patients. Contact HIM DEPT: Healthport Copy Service to process this request for electronic disclosure.

Part C:
Reasons for Denial

To the Requestor:
Lake Health and/or Beachwood Medical Center was unable to process your request for the reason(s) identified below. Should you have any questions or receive additional information, please do not hesitate to contact Lake Health at _____ .

_____ Unable to identify the patient. Please provide additional information and resubmit the request to us. For example: (Date of Birth, Dates of Service, SSN, and/or verify spelling of name)

_____ Unable to release records that are dated after the date of patient's signature. Please provide updated authorization.

_____ This patient was not seen at Lake Health or Beachwood Medical Center _____ .

_____ Authorization was not enclosed with this request.

_____ Authorization is older than one year. Please resubmit your request with updated authorization.

_____ No records at Lake Health or Beachwood Medical Center _____ for the dates requested.

_____ Signature of patient or legally authorized representative is missing.

*_____ Information requested is psychotherapy notes.

_____ Information requested is not found in the medical record.

*_____ Information compiled in anticipation of, or for use in a civil, criminal or administrative legal action or proceeding.

*_____ Health information related to the Clinical Laboratory Improvement Amendments of 1988 "CLIA", to the extent that CLIA would prohibit individual access, or other information that is exempt from CLIA.

*_____ The health information was obtained from another person (other than a health care provider) under a promise of confidentiality and granting access would likely reveal the source's identity.

_____ The medical record is not complete because the physician has 30 days to complete the medical record after the day of discharge.

_____ Access is reasonably likely to endanger the life or safety of the patient or another person.

_____ Access is reasonably likely to cause substantial harm to another person.

_____ Access is sought by the patient's legal representative and access is reasonably likely to cause substantial harm to the patient or another person.

_____ Other: _____

*no right to review of a denial

Except where indicated, you have the right to have a denial reviewed. If you would like a denial to be reviewed, please submit a written statement to the Director of Medical Records at 7590 Auburn Road, Concord Township, Ohio 44077. If you have any complaints regarding Lake Health's or Beachwood Medical Center's HIPAA policies and procedures, please contact the Privacy Officer at (440) 375-8731.

EX4846