

Requestor must present photo ID.

ID Type: \_\_\_\_\_

ID Number: \_\_\_\_\_

MRUN: \_\_\_\_\_ Acct: \_\_\_\_\_

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Release from  Release to (Check one)

- Lompoc Valley Medical Center, 1515 E. Ocean Ave, Lompoc CA 93436
- Comprehensive Care Center, 216 North Third Street, Lompoc CA 93436
- Lompoc Health North Third Center, 136 N Third St, Lompoc CA 93436
- Lompoc Health North H Center, 1225 North H St, Lompoc CA 93436
- Lompoc Health Hematology-Oncology, 1213 Ocean Ave Suite 102, Lompoc CA 93436
- Other \_\_\_\_\_
- Attention: Person or program \_\_\_\_\_

Release from  Release to (Check one) \_\_\_\_\_

Initial here to request records be emailed. If I request LVMC to email or electronically transmit my medical records, records are no longer covered under LVMC HIPAA privacy controls. Email address: \_\_\_\_\_

**By my signature below, I authorize the above-named health care provider to release the information specified below to the designated person/ program or facility that is written on this authorization. The method of the release will depend on the circumstances of the request. This may be photocopies, fax copies, electronic copies, personal review, video, audio or verbal communication by the appropriate health care provider.**

### Purpose(s): for which information is to be used:

- Medical Care  Worker's Compensation  Insurance/Reimbursement
- Personal Use  Legal  Other \_\_\_\_\_



**Information to be released:**

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Radiology Reports ONLY	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Psychological Eval/MSE
<input type="checkbox"/> Diagnostic Images	<input type="checkbox"/> Consults	<input type="checkbox"/> Psychological Test Results
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> EKG / EEG	<input type="checkbox"/> Nurse Notes
<input type="checkbox"/> Emergency Dept. Reports	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Medication List
<input type="checkbox"/> Verbal Information for Insurance billing- Physician name, admit/discharge dates, facility		
<input type="checkbox"/> Other: _____		

**Dates and Conditions of Care:**

Records for treatment dates and/or conditions \_\_\_\_\_

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All admissions or care from LVMC as of the date of my signature.

**Specific Authorization:** I specifically authorize the release of information regarding the following conditions: **(Please initial the appropriate blank)**

\_\_\_\_ Alcohol/Drug Abuse records. Chemical dependency records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 CFR, Part 2. These records cannot be disclosed without patient written authorization unless otherwise provided for in the regulations.

\_\_\_\_ Psychosocial/Psychiatric Information (excludes psychotherapy notes)  
\_\_\_\_ HIV test results (Patient Authorization for EACH release request)  
\_\_\_\_ Genetic test results (excludes therapeutic genetic tests)  
\_\_\_\_ Gender affirming care  
\_\_\_\_ Abortion, abortion-related services, and/or contraception  
\_\_\_\_ Other: Please list: \_\_\_\_\_

**I understand that ....**

- ❖ I may withdraw my authorization at any time by submitting a written request to the Health Information Management Department at Lompoc Valley Medical Center. Authorization may be withdrawn except to the extent that action has been taken in reliance of this authorization.
- ❖ I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.

- ❖ I have a right to receive a copy of this authorization. A copy of this authorization including a fax copy is as valid as the original.
- ❖ Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosures of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

**Expiration:**

I understand that this authorization will automatically expire in 6 months or on this date or event (please specify): \_\_\_\_\_

**Signature:**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

**If a patient is not competent to give consent or is a minor as described by California law, then a parent, legal guardian or legal representative that has been authorized by law to act on behalf of the patient will be required to sign the authorization.**

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative's printed name: \_\_\_\_\_ Relationship: \_\_\_\_\_

In the case of a legal guardian or legal representative, a copy of the documents verifying this status are required at the time of submission of the authorization.