LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

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
☐ 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.*

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:

☐ Discharge Summary	☐ History and Physical	☐ Treatment Plan
☐ Radiology **Reports ONLY**	☐ Operative Reports	☐ Psychological Eval/MSE
☐ Diagnostic Images	☐ Consults	☐ Psychological Test results
☐ Lab Reports	☐ EKG / EEG	☐ Progress Notes
☐ Pathology Reports	☐ Physician's Orders	☐ Nurse Notes
☐ Emergency Dept. Reports	☐ Immunization Record	☐ Medication List

☐ Verbal Information for Insurance billing- Physician name, admit/discharge dates, facility
☐ Other: _____

Dates and Conditions of Care:

☐ Records for treatment dates and/or conditions_____
_____
☐ 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)

____ 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.