Lotus
CENTER OF HEALTH

(910) 726-9976
www.lotuscenterofhealth.com
1721 New Hanover Medical Park Dr
Wilmington, NC 28403

Authorization for Use, Disclosure, and/or Request of Protected Health Information

Patient Name: _____

Date of Birth: _____/____/_____Phone Number: _____ Last 4 SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specific information being requested:

History/Office Notes [ ]
Laboratory Test results [ ]
Pap Smears [ ]
Mammograms [ ]
Immunizations [ ]
Pathology reports [ ]
Radiology reports (includes Bone Density, CT/CTA, MRI/MRA, Vascular, etc.) [ ]
Other: (Please be as specific as we will only be able to provide the specific information you list)

_____

Time Frame of records to be released: (examples: 1 year, 2016 – current, or last 3 visits)

_____

Entities Authorized to Use, Disclose, or Receive: If persons or organizations authorized below are not health care providers, they may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Records Requested FROM:
Where are the records coming from?

Name of Provider or Organization:

_____

Address: _____

_____

Phone: _____

Fax: _____

Records Being Sent TO:
Where are the records being sent?

Name of Provider or Organization:

_____

Address:_____

_____

Phone: _____

Fax: _____

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Preference for receipt of records:

Mail [ ]

Fax [ ] ***(Please send by mail if fax exceeds 50 pages)***

Other [ ] _____

*****PLEASE DO NOT SEND DISCS**

The purpose of the use, disclosure, and/or request: fees may apply based on form of and reason for release of information.

Continuation of care [ ]

Insurance [ ]

Attorney [ ]

Personal use [ ]

Other [ ] _____

This Authorization will expire: (choose one)

2 years after death of patient [ ]

Upon written revocation [ ]

Future Date: _____

On the occurrence of the following event: _____

By signing below, I understand:

- I authorize the use and/or disclosure of my protected health information as described in this document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.
- Lotus Center of Health may not condition my treatment on my refusal to sign this authorization.

Signature: _____

Date: _____ Last 4 digits of patient's social security number: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____