

Lincoln Internal Medicine
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**AUTHORIZATION FOR LINCOLN INTERNAL MEDICINE
TO RELEASE HEALTH INFORMATION**

Patient Name: _____ DOB: _____

I authorize Lincoln Internal Medicine to release health information to:

Name of person/entity that records are to be released to

Address, City, State and Zip

Please specify the type of health information that you authorize to be released:

MEDICAL MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information: _____

Date(s) of treatment: _____

The following information will not be released unless you specifically authorize it:

- I specifically authorize release of information pertaining to drug and alcohol abuse diagnosis or treatment (C.F.R. §2.34 and §2.35)
- I specifically authorize the release of HIV/AIDS test results (Health and Safety Code § 120980 (g).
- I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j).

The purpose of this release is:

- At the request of the patient/patient representative
- Other (state reason): _____

Notice:

LIM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights:

This authorization to release health information is voluntary. Treatment, payment, enrollment of eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine the entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative and delivered to April Hillard, Health Information Manager at Lincoln Internal Medicine. The revocation will take effect when LIM receives it, except to the extent that LIM or others have already relied on it.

You are entitled to receive a copy of this authorization.

Expiration of Authorization:

Unless otherwise revoked, this authorization expires on _____ (insert applicable date or event).
If no date is indicated, the authorization will expire in 12 months from the date of my signing.

Print Name

Signature (Patient, Parent, Guardian)

Date

Time

Relationship to Patient (i.e. Parent
Guardian, Conservator, Patient Representative)

Witness (only if patient is unable to sign)
Interpreter