AUTHORIZATION FOR USE OF OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Leesburg Regional Medical Center, Inc. / The Villages Regional Hospital, it's affiliates, employees or agents to

_____ release _____ obtain copies of the medical records of _____

(check one of the above)

To/From: _____

Name of Individual, Healthcare Facility, or Agency

_____

Address City State Zip Code

For the purpose of: _____ Continued Treatment _____ Personal Records _____ Other (please specify)

_____

Date(s) of Service: From: _____ To: _____

This authorization will expire on the following date, event or condition: _____

_____.

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and /or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling / testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information.

Information to be released or obtained includes: Place your initials by each item that applies.

_____ Mental Health _____ Psychotherapy Notes _____ AIDS Information

_____ Drug and/or Alcohol _____ HIV Testing _____ Genetic Counseling/Testing Information

The specific records to be released or obtained are: Place your initials by each item that applies.

_____ Complete Record
_____ Abstract of Record
_____ Consultation/Progress Notes(s)
_____ Lab only _____ Radiology only
_____ All diagnostic test results
_____ Pathology/Operative Reports(s)
_____ Therapy Records
_____ Other (please specify)

_____ _____

Patient / Legal Representative or Parent / Legal Guardian Date of Authorization

_____ _____

Social Security Number Date of Birth

_____ _____

Translator or Interpreter's Name Identification Shown

Address: _____ _____

Telephone Number

_____ _____

Witness: _____ Date

Official Use Only: _____

Name of Person Releasing Information Date Number of Pages