Lawrence General Hospital
So good. So caring. So close.

Authorization for the Disclosure of Medical Records

LGH Health Information Services
1 General Street
Lawrence, MA 01842-0389

Phone: 978-683-4000 Ext. 2047
Fax: 978-557-9948
Email: medicalrecords@lawrencegeneral.org

LGH Medical Record # ______________________

Patient Name: ____ Date of Birth: ________________________

Address: ____
Street City State Zip Code

Telephone #: ____________________________ Email: ___________________________________

Lawrence General Hospital has my permission and authorization to release to, discuss with, and/or receive from the person/organization named below the following information about the above named patient:

Information to be Released:

☐Medical Record Abstract – History & Physical, Operative Report, Consults, Test Reports, or Discharge Summary:

____

☐ Pathology (please specify what materials): ____

☐Other - Specify information to be released: ____

Purpose of the Release: ____

____

Information to be released to:

Person/Organization: _______________________________________ Attention of: ________________________________

Address: ____
Street City State Zip Code

Telephone #: ____________________________ Email: ___________________________________

Fax**:** ___________________________________

I hereby authorize Lawrence General Hospital (LGH) to release and collect information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded. I am aware that LGH cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at LGH may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

This authorization will end (enter date or event): ____

I acknowledge that I can cancel this authorization in writing at any time, except to the extent that LGH has relied upon it. For example, if I cancel it after LGH has sent requested records, LGH will not retrieve those records. Instructions for canceling this authorization are included in the LGH Notice of Privacy Practices. I understand that LGH will continue to provide care, even if I do not authorize this release.

____ ______________________________
Signature of Patient or Legal Representative Date

____ ______________________________
Printed Name of Patient or Patient's Representative Relationship to Patient