LANTERN HEALTH | direct primary care

Updated April 1, 2021

Authorization for Release of Information

Patient Name: ____ Date of Birth: ____________

Address: ____ Phone: __________________

____

I, the above listed patient, hereby authorize the following healthcare facility/provider to disclose my health information as described below.

Facility/Physician Name: ____

Facility Address: ____

Facility Phone: ____

Facility Fax: ____

Dates and Type of Information for Disclosure:

[ ] 3 years prior to last date seen   [ ] Entire record (PHI, visits, labs/pathology, etc.)

[ ] Date range: ______________   [ ] Specific Request/Other: __________________

Purpose for Disclosure:

[ ] Healthcare   [ ] Legal   [ ] Insurance   [ ] Personal   [ ] Worker's Comp   [ ] Other: _________

This information may be disclosed to and used by the following individual or organization:

Facility/Physician Name: _Lantern Health_______________________________________

Facility Address: _______84 Coxe Avenue, Suite 240______Asheville, NC 28801_____

Facility Phone: _______828-552-5757____

Facility Fax: _____________828-552-5819____

Requested Format: [ ] US Mail   [ ] Pick-up   [ ] Fax   [ ] Other: _______________________

My signature below indicates that I understand the following:

- This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
- As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- My decision to sign this authorization will not have an effect on the treatment provided to me by the health care provider, the cost of that treatment, or my benefits.
- I may revoke this authorization at any time by notifying Lantern Health in writing.
- Revoking this authorization will not affect any disclosures made prior to revoking this authorization.
- Unless revoked or an expiration date is indicated here __________, this authorization will expire in 1 year.
- After release, my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permissions.
- Lantern Health will not use or share my health information without my permission, except as allowed or required by law.
- This form will not be used for marketing or research.
- I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my health information as described in this form.

Printed name: ________________________________

Signature: ____________________________________ **Date:** ____________ **Time:** ____________

Patient or Representative Signature

If representative, please indicate relationship to patient:

[ ] Parent [ ] Legal Guardian [ ] Executor of Estate [ ] Power of Attorney [ ] Other: _________

Contact Information

To ask questions or comment about this Authorization for Release of Information, contact us at:

Lantern Health
84 Coxe Avenue, Suite #240
Asheville, NC 28801

Phone: (828) 552-5757
hello@lanternpc.com