

Authorization to Release Health Information

Prefer to sign electronically? Visit lotusdirectcare.com/resources/records-release. Return this form by fax to (855) 457-1293 or bring it to the office.

1. Patient

Patient full name

Date of birth

Other names used on records (optional)

2. Direction (check one)

- ☐ Lotus Direct Care requests my records FROM the provider below
☐ Lotus Direct Care sends my records TO the person or provider below
☐ Both (exchange records)

Other provider, facility or person

Address / phone / fax

3. Information to be shared

- ☐ Complete medical record ☐ Office visit notes ☐ Lab and test results
☐ Imaging reports ☐ Medication and immunization lists ☐ Billing records

Dates of service (e.g. all, or 2022 to present)

Other / description

Sensitive records are included ONLY if checked below:

- ☐ Substance use disorder treatment records (42 CFR Part 2) ☐ Mental health treatment records (Wis. Stat. 51.30)
☐ HIV test results (Wis. Stat. 252.15)

4. Purpose and expiration

- ☐ Continuing my care ☐ At my request ☐ Insurance/benefits ☐ Legal ☐ Other

This authorization expires on (date). If blank, one year from the date signed.

5. I understand that

1. I may revoke this authorization at any time by notifying Lotus Direct Care in writing. Revoking it does not affect information already released in reliance on it.
2. Lotus Direct Care will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
3. Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law (HIPAA), except substance use disorder records protected by 42 CFR Part 2.
4. If I authorized substance use disorder records: they are protected by 42 CFR Part 2. Federal law prohibits a recipient from using or disclosing them further, or using them in any civil, criminal, administrative or legislative proceeding against me, except as permitted by 42 CFR Part 2, my written consent or a qualifying court order.
5. I am entitled to a copy of this signed authorization.

6. Signature

Signature of patient or legal representative

Date

If signed by a representative: printed name and authority (parent, guardian, health care POA)