Consumer Name (Printed): _____ Phone#_____

Consumer Email Address:_____

Birth Date:_____

Consumer Address:_____

_____

Medical Records#_____
(If known)

WHO:
I hereby authorize:_____**to take the following action.**
(Life's Energy Wellness Center Provider(s) Name)

Action Requested: (Check one)

☐ Provide a copy of My health information to me ☐ Let me look at My Health Information (I am not requesting a copy)

☐ Release My Health Information to: ☐ Discuss My Health Information with: ☐ Obtain copies of My Health information from:

_____
(recipient name of other person or entity receiving Health Information)

_____
(Street Address)

_____ _____ _____
(City) (State) (zip code)

_____ _____
Secure Email address of recipient Fax Number
(we cannot call before faxing)

WHAT:
For this Authorization, "My Health Information" means (Please Check one or more) and may include information regarding somatic health treatment, mental health treatment, substance use disorder treatment, gambling treatment:

☐**Admision History & Physical** ☐ **Mental Health Treatment Records** ☐ **Admission Psychiatric**

☐**Diagnostic Test/Results** ☐ **History of Allergies** ☐ **Psychiatric Evaluation/Diagnosis**

☐**Discharge Summary** ☐ **Immunization Record** ☐ **Psychological Education Report**

☐ **Drug & Alcohol Treatment Records** ☐ **Progress Notes** ☐ **Psychosocial Assessment**

☐ **Other:**_____

If I have initialled here(_____), this Authorization does **NOT** include records from other providers that are a part of my Life's Energy Wellness Center Inc. records included in this request. (If this blank is not initialled, those records **will be** included.

WHY

☐ At my request ☐ For my healthcare/treatment ☐For legal purposes ☐ For payment/ insurance purposes

Other:_____

FORMAT: I request that the copy be provided (where possible/available):

☐ **on paper**

☐ **through a secure web portal, with notice provided to my email account at:**_____

☐ **by unencrypted e-mail to this email address:** _____

☐ **by other electronic means (if agreed upon by LEWC Inc. records department):**_____

☐ **fax #:**_____

Important Notification: I understand that if information is not encrypted or password protected that it is my responsibility to take extra precautions to protect the data received and not to lose or misplace. Additionally, I understand that unencrypted email is not secure-that means it could be intercepted and seen by other; In addition, I understand that there are risks with unencrypted email including misaddressed/misdirected messages; email accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to to receive My Health information electronically, or unencrypted email, I am acknowledging and accepting these risks. I understand there may be a fee for a copy of my Health Information. I understand that all fees will be in compliance with the law. I agree to pay this fee. I understand this authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization of not. I understand that if I make a request to end this authorization, it will not include information that has already been used or disclosed on my previous permission. In any event, the recipient should not re-disclose such information without my further written authorization unless otherwise provided by state or federal law. I understand that if my record contains information relating to chronic illness, substance use disorders, communicable diseases including HIV, AIDS or related illness, psychological or psychiatric conditions, or genetic testing this disclosure will include that information unless I specifically exclude such information from disclosure.I understand these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of the records from making and further disclosures to third parties without the written consent of myself the client. I understand I will not be required to sign this form as a condition of services provided and may refuse to sign this Authorization. I understand that if service is requested by a non-treatment provider (e.g., Insurance company for the sole purpose of creating health information (e.g., physical exam), that service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given. I understand I have a right to this signed authorization that I may keep for my records. I understand that this authorization to release information is granted for one year expiring on:_____and may be rescinded/revoked upon receipt of my verbal, written, or taped request. I understand that I can end this authorization (permission to disclose information) at any time. Once My Health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.

By signing I acknowledge that I have read, understand and accept the terms and policies of the releasing agency.

Signature of Consuemer Only:_____ Date:_____/_____/_____

(required)

Representative Printed Name:_____ **Date:**_____/_____/_____

Signature of Parent/Legal Guardian/ Legal Representative:_____

LEWC INC (STAFF USE ONLY)

Date Request Was Received	Date: Yes or No	Remarks
Form Received by:(Staff Name)	□ Yes □No	
ROI attached with request: (Yes or No)	□ Yes □No	
Identification attached with request: (Yes or No)	□ Yes □No	
Receiving entity contact information verified: Yes or No)	□ Yes □No	
Date Consumer/Entity informed of Request in Processed:	□ Yes □No	
Date Request Finalized/Staff Initials:		

Medical Records & Privacy Information

Obtain Copies of Your Records

Monday – Thursday 8:00 am –5:00 pm (excluding holidays)

MD Statute allows up to 21 days to process requests for copies of medical records. We prioritize record copy requests that are related to direct patient care. If your records are needed for a healthcare related appointment, please provide the appointment date. We are not able to fulfill requests when the request form is incomplete. Incomplete request forms will be returned. All records requests are completed in the order they are received.

If you are picking up a copy of your record, photo ID will be Required and requested. Please note that only the patient or patient legal representative may pick up a copy of the record, unless otherwise indicated in writing by the patient or patient representative.

For Requests from Persons Other than the Patient

To obtain a copy of medical records for someone other than yourself, download the applicable form from our website.

Have the form completed in its entirety by the patient or legal patient representative clearly stating the dates of service, the specific type of record(s) desired and all other information indicated on the form. These forms may also be obtained in the office or you may request for the form(s) to be mailed or faxed to you. Mail, fax, or drop off the completed form to the applicable address/fax number listed below:

Costs

In accordance with Federal and Maryland law, processing fees and copying charges may apply. If the record is being released directly to you or your private physician or another health care facility, there is no charge associated with copying your records.For copies released directly to a third party upon your request or the request of your patient representative, a fee of $35.00 will apply for the portion of your medical record maintained electronically, and a fee of $0.07 per page plus a $0.90 flat labor fee will apply for the portion of your medical record maintained on paper or secure electronic option, consistent with Federal and Maryland state law. Additional record copy fees, consistent with Federal and Maryland law, will be applied to all third party requests.

If there is a charge for records, an invoice will be issued electronically with online payment options, including payment instructions.