Instructions for completing the Lockheed Martin Wellness Center Authorization to Use or Disclose Protected Health Information Form

1. Please complete the form, typing in the required information to ensure the Privacy Office can read the information on the form.
2. Section 2 – The “From” and “To” date lines only need to be completed if you are requesting information involving a certain date range contained within the medical record. If you are requesting everything from a given category, like all your immunizations, your entire medical record or all lab reports for example, you do not need to complete these date lines.
3. Section 3 – If you are a legally authorized representative completing this form on behalf of another person, you must complete the “If Purpose of Request is other than Patient’s Request” line in addition to the Recipient Information.
4. After typing in the required information, print off and sign\* and date the form. The Privacy Office will not respond to requests made on forms that are not signed and dated.

*\*Only current Lockheed Martin employees can use an electronic signature for the required patient or authorized representative signature field.*

1. Email or mail the completed and signed/dated form using the addresses listed at the bottom of the form.
2. Please be advised that Lockheed Martin has up to 30 calendar days to produce the requested medical records.

Scroll down to view form.

**Lockheed Martin Wellness Center**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

**(Not valid for research, marketing, or psychotherapy note requests)**

**Section 1 – Patient Information:**

Last Name: Click or tap here to enter text. First Name: Click or tap here to enter text. MI: text.

Other Name Used: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Mailing address: Click or tap here to enter text. City: Click or tap here to enter text.State: text.

Home phone: Click or tap here to enter text. Cell phone: Click or tap here to enter text.

Work phone: Click or tap here to enter text. Current or Last LM Work Location: Click or tap here to enter text.

Current or Last Manager’s Name: Click or tap here to enter text. LMPID# Click or tap here to enter text.

**Section 2 – Record Request**

I hereby request access to the protected health information in my medical record **FROM** date enter a date.

**TO** date Click or tap to enter a date. maintained or created by the following

**LM Wellness Center Name**: Click or tap here to enter text.

**Check all the following that apply**:

Immunization Records  Entire Medical Record  X-ray Reports

Office Visit/Progress Notes  Restrictions/Accommodations  Lab Reports

Other Click or tap here to enter text.

**Section 3 - Recipient Information** (required)Your record will be FedExed or mailed to the recipient below.

Name: Click or tap here to enter text.

Mailing Address: Click or tap here to enter text.

Phone: Click or tap here to enter text.

If **Purpose of Request** is other than Patient’s Request (required):  Legal  Insurance

Other Click or tap here to enter text.

**I understand:**

* I may revoke this authorization at any time by providing my written revocation to HIPAA Privacy Office, Lockheed Martin Corporation, 6801 Rockledge Drive, CCT-115, Bethesda, MD 20817. The revocation will not apply to information that has already been released in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be one (1) year from date of signature. Otherwise, this authorization will expire on **(Date)** Click or tap to enter a date..
* The information in the patient’s health record may include information related to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
* After the above information is disclosed, it may be re-disclosed by the person or entity that received it, and the information may not be protected by federal privacy laws or regulations.
* Authorizing the use or disclosure of the information identified above is voluntary. This form is not required in order for a patient to receive health care treatment, payment, enrollment, or eligibility for benefits.
* I have a right to receive a signed copy of this authorization form.

Click or tap here to enter text. Click or tap here to enter text.

**Signature of Patient or Authorized Representative** (required)  **Relationship to the patient**

Electronic signature permissible for current LM employees

Click or tap here to enter text. Click or tap to enter a date.

Print name of Patient or Authorized Representative Date (required)

All requests completed by former and retired employees or non-employees can be to E-mailed to:

[hipaa-lmc.fc-corp@lmco.com](mailto:hipaa-lmc.fc-corp@lmco.com)

Or Mailed to: HIPAA Privacy Office, Lockheed Martin Corporation, 6801 Rockledge Drive, CCT-115, Bethesda, MD 20817