

**ATTACHMENT A**  
**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES PATIENT IDENTIFICATION**

Patient Name \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address:

\_\_\_\_\_  
Telephone #: \_\_\_\_\_

**Information To Be Released – Covering the Periods of Health Care**

From (date) \_\_\_\_/\_\_\_\_/\_\_\_\_

To (date) \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe type of information to be released:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose of Request**

Marketing purposes as described here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**1. Payments to Facility**

This marketing activity involves direct or indirect compensation/payment from a third party to Name of Facility for this use of protected health information.

Check One: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Initials

**Person Authorized to Receive Information**

Name: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Initials

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2. Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at [location & mailing address]. Unless revoked, this authorization will expire on the following date or event \_\_\_\_\_.  
If no expiration date is set forth, this authorization will expire 180 days from date of signature.

3. Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

4. Signature of Patient or Personal Representative Who May Request Disclosure

I understand that LSUHSC-NO may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize LSUHSC-NO to use and disclose the protected health information specified above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Authority to Sign if not patient:

\_\_\_\_\_

Identity of Requestor Verified via: Photo ID    Matching Signature    Other,  
Specify \_\_\_\_\_

Verified by: \_\_\_\_\_