

Authorization for Release of Protected Health Information Patient Identification

Patient Name: _____ Date of Birth: ____/____/____
Address Street _____
City/State/Zip _____
Social Security #: _____ Telephone: _____

Authority to Release Protected Health Information

I hereby authorize _____ to release the information identified in this authorization form from the medical records of _____ and provide such information to _____

Information To Be Released – Covering the Periods of Health Care

From (date) ____/____/____ to (date) ____/____/____

Please check type of information to be released:

- | | | |
|----------------------------------------------------|------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Complete health record | <input type="checkbox"/> Diagnosis & treatment codes | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> X-ray films / images |
| <input type="checkbox"/> Photographs, videotapes | <input type="checkbox"/> Complete billing record | <input type="checkbox"/> Itemized bill |
| <input type="checkbox"/> Other, (specify) _____ | | |

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual): _____

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

I understand 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

I understand 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

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to _____ at _____, Unless revoked, this authorization will expire on the following date, or after the following time period or event _____.

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.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge _____ of any liability and the undersigned will hold _____ harmless for complying with this Authorization.

Signature: _____ Date: ____/____/____

Description of relationship if not patient: _____

ATTACHMENT B

MAKE TWO COPIES. PROVIDE ONE TO PATIENT. MAINTAIN OTHER IN LSUHSC-NO FILES.