ATTACHMENT A

PERMISSION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR LSUHSC-NO FACILITY DIRECTORY

I am exercising my right to permit or prohibit inclusion of my Protected Health Information (PHI) in a directory of patients maintained by the LSUHSC-NO throughout the course of this admission.

(Check the box that applies and sign at the bottom of the page)

☐ I do not wish to be listed in LSUHSC- NO Directory.

☐ I do wish to be listed in LSUHSC- NO Directory and I agree that my name, location in LSUHSC- NO, brief description of my condition, and religious affiliation (accessible only to clergy members) can be included in LSUHSC- NO Directory.

Signature: _____ Date: _____

Printed Name: _____

Relationship if not Patient: _____

Patient's Date of Birth: _____ Patient's SS#: _____

Patient's Address: _____

If option communicated orally by patient, recorded by:

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

Department/Title: _____