



**Authorization for Release of Protected Health Information**

ATTACHMENT B

Make two copies. Provide one to patient. Maintain original in LSUHSC-NO Files.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address Street \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
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:

- Complete health record       Diagnosis & treatment codes       Discharge summary       Psychotherapy Notes
- History and physical exam       Consultation reports       Progress notes      *(If above is checked, any other PHI*
- Laboratory test results       X-ray reports       X-ray films / images      *must be listed on a separate*
- Photographs, videotapes       Complete billing record       Itemized bill      *authorization form)*
- 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”): \_\_\_\_\_

**If this authorization is for the purposes of marketing or the sale of PHI, will LSUHSC-NO receive any payment as a result of this authorization? Check One:  Yes  No  Initials**

**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 LSUHSC-NO and its officers, directors, employees and students of any liability and the undersigned will hold them harmless for complying with this Authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Description of relationship if not patient: \_\_\_\_\_