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:_____