

Authorization for Use and Disclosure of Protected Health Information

Patient Identification:

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Complete Address: \_\_\_\_\_
Social Security #: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

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, History and physical exam, Laboratory test results, Photographs, videotapes, Discharge instructions, Other (specify):
Diagnosis and treatment codes, Consultation reports, Radiology reports/images, Complete billing record, Pulmonary function results
Discharge summary, Progress notes, Cardiac imaging, Itemized bill

Purpose of Request

- Treatment or consultation, At the request of the patient, Billing or claims payment

(Indicate which applies) Send To / Obtain Information From:

- Paper, CD, Electronic Portal, Email

Release to Name: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

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

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 - GINA, section 201 7 A and B). To authorize release of this information, please read and sign the following:

- I, \_\_\_\_\_ authorize the release of alcohol and/or drug abuse treatment and information.
I, \_\_\_\_\_ authorize the release of HIV test results and/or HIV treatment information.
I, \_\_\_\_\_ authorize the release of psychiatric information.
I, \_\_\_\_\_ authorize the release of genetic testing information.

Time Limit and 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 Monroe Medical Center at Ochsner LSU Health Shreveport, 4864 Jackson Street, Monroe, Louisiana 71202, Health Information Management Department. Unless revoked, this authorization will expire on the following date or event \_\_\_\_\_ or 180 days from the date of signature.

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Monroe Medical Center at Ochsner LSU Health Shreveport and its affiliates and their staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I authorize Monroe Medical Center at Ochsner LSU Health Shreveport to release the protected health information specified above.

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

Authority of Personal Representative to Request Disclosure: \_\_\_\_\_

Identify of Requestor Verified via: Photo ID Other, specify: \_\_\_\_\_