LSU Health Care Services Division for EKL Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date ____ /____/_____ SS# _____-_____-_____

Address: _____City_____ State_____ Zip_____ Phone (____)_____-_____

Authority to Release Protected Health Information: I, _____, hereby authorize LSU Health Care Services Division as Custodian for Earl K. Long Medical Center__ Address P.O. Box 91308 City Baton Rouge State Louisiana Zip70805 to release the information identified in this authorization form from the Medical Records of _____ and provide such information to _____ Address_____ City_____ State ____ Zip _____Phone: (____) _____-_____ Fax: (____) _____-_____ Department (optional) _____

Information to be Released-Covering the Period(s) of Health Care: From (date) _____ To (date) _____

Please check type of information to be released:

__Complete health record	__Diagnosis & treatment codes	__Discharge summary
__History & physical exam	__Consultation reports	__Progress notes
__Laboratory test results	__X-ray reports	__X-ray films / images
__Photographs, videotapes	__Complete billing record	__Itemized bill

__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 diseases, 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 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 my treatment or payment for services will not be denied if I do not sign this form. However, if healthcare 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: _____Relationship: _____

FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL BE RETURNED