THE BATON ROUGE CLINIC AMC

7373 Perkins Road • Baton Rouge, Louisiana • 70808-4326 • 225/923-1515 or 225/769-4044

# Authorization for Release of Protected Health Information from The Baton Rouge Clinic, AMC

**Patient Identification**

Printed Name: _____ Date of Birth: _____

Address: _____

_____

_____

Social Security #:_____ Telephone: _____

**Authority to Release Protected Health Information**

I hereby authorize The Baton Rouge Clinic, AMC 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 |
| [ ]History and physical exam | [ ]Consultation reports | [ ]Progress notes |
| [ ]Laboratory test results | [ ]X-ray reports | [ ]X-ray films / images |
| [ ]Photographs, videotapes | [ ]Immunization Records | [ ]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 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 The Baton Rouge Clinic, AMC, ATTN: Medical Records Manager at 7373 Perkins Road, Baton Rouge, LA 70808. 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 The Baton Rouge Clinic, AMC of any liability and the undersigned will hold The Baton Rouge Clinic, AMC harmless for complying with this Authorization.**

Signature: _____ Date: _____

Description of relationship if not patient: _____