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

Patient Identification

*Printed Name: _____ *Date of Birth: _____

*Address: _____

*Social Security #: _____ *Telephone: _____

*Email: _____

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:

Name	Address	Telephone #
Name	Address	Telephone #
Name	Address	Telephone #

Information to Be Released – Covering the Periods of Health Care

*From (date) _____ *To (date) _____
(e.g. mm/dd/yyyy or ALL for all past dates) **(e.g. mm/dd/yyyy or ALL for all future dates)**

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__ ***Circle One***

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. **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. **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 a t 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/event_____, or 1 year after the form was signed.

(Expiration Date)

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 heal th 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:_____

If this request is urgent, please call 225-246-9770. For any questions regarding your request, please call (225) 246-9770 or email us at medrecords@brclinic.com

*** Information is required to process request.**