



**Authorization for Release of Protected Health Information to 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 \_\_\_\_\_ to release the information identified in this authorization form from the medical records of \_\_\_\_\_ and provide such information to:

The Baton Rouge Clinic, AMC  
7373 Perkins Road  
Baton Rouge, LA 70808  
Physician Fax# \_\_\_\_\_  
Phone# 225-246-9770 or 225-246-4770  
Email Address: medrecords@brclinic.com

**Information To Be Released – Covering the Periods of Health Care**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

***Please check type of information to be released:***

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> 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. **Circle 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. **Circle 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

\_\_\_\_\_.  
(Expiration Date 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: \_\_\_\_\_