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

Patient Identification:

Printed Name: ____ Date of Birth: ____________________________

Address: ____

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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:

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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*): ____

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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., "At the request of the individual"*):

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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, **Yes** **No** I agree to its release.

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/event ____, or 1 year after this form was signed.

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 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 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*): ____