



**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: 225-246-9125***

**Information to be Released – Covering the Periods of Health Care:**

From (Date): ***1-1-2015*** To (Date): ***present***

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

<input checked="" type="checkbox"/>	<b>Complete health record</b>	Diagnosis & treatment codes	Discharge summary
<input type="checkbox"/>	History and physical exam	Consultation reports	Progress notes
<input type="checkbox"/>	Laboratory test results	X-ray reports	X-ray films / images
<input type="checkbox"/>	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., "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, agree to its release.

**Yes No I**

**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*): \_\_\_\_\_