

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB		
ADDRESS		SSN		
CITY	STATE	ZIP		
PROVIDER AUTHORIZED TO RELEASE THE PHI:		ENTITY RECEIVING THE PHI:		
LA390 JEFFERSON ORTHOPEDIC CLINIC 920 AVENUE B MARRERO, LA 70072 FAX: (504) 349-6844		NAME		
		ADDRESS		
		CITY	STATE	ZIP
		ATTENTION:		
This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.				
Date:		Event:		
Purpose of this Disclosure:				
PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE				
Description		Start Date	End Date	
<input type="checkbox"/> All PHI in the record				
<input type="checkbox"/> Progress Notes				
<input type="checkbox"/> Laboratory Tests				
<input type="checkbox"/> X-Ray Tests / Reports				
<input type="checkbox"/> History and Physical Examination				
<input type="checkbox"/> Discharge Summary				
<input type="checkbox"/> Consultation Reports				
<input type="checkbox"/> Itemized Billing Statement				
<input type="checkbox"/> Other:				
The following information will be released when included in the above information unless you indicate otherwise:				
<input type="checkbox"/> AIDS or HIV test results		<input type="checkbox"/> Psychiatric or mental care / treatment		
<input type="checkbox"/> Alcohol, drug or substance abuse treatment		<input type="checkbox"/> Other (specify):		
I UNDERSTAND THAT:				
1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY. 2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION. 3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION. 4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE DISCLOSED. 5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.				
Signature of Patient:		Date:		
Signature of Patient's Representative (if necessary):		Date:		
Personal Representative's Relationship to Patient:				