Our Lady of the Lake Regional Medical Center
Our Lady of Lourdes Regional Medical Center
St. Francis Regional Medical Center
St. Elizabeth Hospital
Our Lady of the Angels Hospital

# Authorization for Release of Protected Health Information (PHI)

Patient's Name/Address/Phone

| Medical Record / Fin #: | Birth Date: | Last 4 Digits of Social Security Number |
|---|---|---|
| | | |

Requester's Name/Relationship to Patient:

Provider's Name/Address:

This authorization shall expire on this expiration date______________________________
** If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed

**Purpose of Disclosure**

Medical Care Legal Insurance Personal Other

**Description of Information to be used or disclosed.**

Is this request for psychotherapy notes?
Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
No, then you may check as many items below as you need

Information to be disclosed:

| | | | |
|---|---|---|---|
| Discharge Summary | History & Physical Exam | Operative Report | EKG |
| ER Record | Laboratory Report | Radiology Report | Itemized Bill |
| Pathology Report | Consultation | Other: ______________________________ | |

Date of Service: ___________ to ___________

The information is to be released to:

_______________________________________________________________________________

_______________________________________________________________________________

(address) (city) (state) (zip)

The following information will be released when included in the above unless you indicate otherwise:

❑ Do not release and AIDS or HIV test results
❑ Do not release any records of psychiatric care
❑ Do not release any records of alcohol/drug abuse
❑ Do not release records of genetic testing

1. I understand that this authorization is voluntary and that I may refuse to sign per the Health Insurance Portability and Accountability Act (HIPAA). Louisiana law requires a written authorization in order to release protected health information.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released may no longer be protected by federal regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may get a copy of this form after I sign it.______________________________________________

**I have read the above and authorize the disclosure of the protected health information as stated.**

| Signature of Patient or Legal Representative: | Date: |
|---|---|
| Print Name of Patient or Legal Representative: | Relationship to Patient or Legal Representative: |