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:

[ ]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) _____

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: _____