

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL (PRINT)		DATE OF BIRTH		DATE
ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

I hereby authorize Baton Rouge General Medical Center to use and/or disclose the information checked and/or listed below for the time period beginning on _____/_____/_____ and ending on _____/_____/_____.
 Date Date

<input type="checkbox"/> Billing Statements <input type="checkbox"/> Care Plans <input type="checkbox"/> Complete Health Care Record(s) <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Dental Records <input type="checkbox"/> Diagnoses (including those relating to alcohol, drug abuse, mental health, AIDS or HIV status, if any) <input type="checkbox"/> Discharge Status <input type="checkbox"/> ER Department Record <input type="checkbox"/> Genetic Testing <input type="checkbox"/> History and Physical Examination	<input type="checkbox"/> Lab Reports (including alcohol or drug screening, if any) <input type="checkbox"/> Marketing (explain): _____ <input type="checkbox"/> Nurses' Notes <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Photographs, Video Tapes, Digital, or other images <input type="checkbox"/> Physician Orders <input type="checkbox"/> Physician's Progress Notes / Integrated Progress Notes <input type="checkbox"/> Psychosocial Assessment	<input type="checkbox"/> Psych Eval based on testing material <input type="checkbox"/> Verbal Reports <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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This information is to be released to _____ for the following purpose(s):

- | | |
|--|--|
| <input type="checkbox"/> Continuation of Treatment | <input type="checkbox"/> Processing of Insurance Claim |
| <input type="checkbox"/> Application of Insurance | <input type="checkbox"/> Attorney (Name) _____ |
| <input type="checkbox"/> At the Individual's Request | |
| <input type="checkbox"/> Other (specify): _____ | |

Release Records Electronically? Yes No

For Electronic Records Release: Release to patient on CD Release to patient through secure email
 Email address: _____

- If authorizing certain marketing activities, I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.
- Unless otherwise revoked by me, I understand that this authorization will expire in one year or upon the completion of the use or disclosure of the information for the purpose it was intended, whichever is earlier.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.
- I hereby release the facility, its employees, officers, and healthcare professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that I may revoke this request at any time by providing the facility with my written notice of such revocation as outlined in the facility's Joint Notice of Privacy Practices.
- I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization.
- I understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

Signature of Individual _____

Signature of Witness _____

Printed Name of Individual _____

Printed Name of Witness _____

_____/_____/_____
Date

_____/_____/_____
Date

A copy of this record must be provided to the person making the request and a copy must be filed in the Medical Record. If representative is signing, the relationship to individual should be listed. If individual is under 18, the parent or guardian must sign.

