AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CHRISTUS CENTRAL LOUISIANA SURGICAL HOSPITAL

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

PATIENT NAME: _____ DATE OF BIRTH _____

PATIENT'S ADDRESS: _____

CITY/STATE/ZIP _____

PHONE # (provide direct # where you can be reached regarding this form or where a voicemail message may be left for you)

Home_____ Cell/other_____

Disclosure of protected health information is made at my request for:

☐ Change of Insurance ☐ Referral ☐ Continuity of Care/Other_____

☐ Change of Physician ☐ Personal records ☐ Legal or attorney use (specify, if other)

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED/CHECK ALL THAT APPLY:

☐ **All Records of treatment*** ☐ Records from (date) _____to (date) _____

☐ Billing records, statements for services ☐ Lab/diagnostic/ test results only

☐ Nursing notes, documentation ☐ Imaging/Radiology reports/

☐ Operative or procedure notes ☐ Discharge Summary

☐ Physician notes, orders, history & physical ☐ Other records/please provide specific information _____

☐ Disc or film _____

***"**All records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices and information from all other health care providers used for our care and treatment in the hospital/facility). Some records have federal privacy protections. This does not include psychotherapy notes, which require separate "authorization to disclose".

The Facility or Hospital named above is authorized <u>to disclose (provide)</u> the records/information.

Persons, facilities, providers or others who are authorized <u>to receive</u> the records/information:

Physician/healthcare facility or provider name_____

Address_____

City/State Zip_____

Phone #_____

Attorney/law firm/other_____ **N/A** ☐

Address_____

City/State Zip_____

Phone #_____

Please complete more than one form if multiple disclosures to multiple providers are requested.

I authorize the disclosure of the information described. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law, and I am requesting that any and all such protected records be released under this authorization. If I revoke this authorization, it will have no effect on actions taken or information already sent as authorized by his form. I understand that the hospital/facility will not condition treatment, payment, enrollment or eligibility on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it. I permit disclosure of information upon presentation of a photocopy of this authorization. I understand that I have the right to revoke this authorization. I may do so by delivering or mailing a written revocation (which is a request withdrawing or cancelling this authorization) to this facility/hospital, any other healthcare provider or attorney or law firm if named above. Unless otherwise revoked, the authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 (one) year from date signed. Finally, I understand that there may nominal charges for these records and that will be discussed with me at the time this "Authorization" is presented or received.

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____

Signature of Patient (or Patient's Personal Representative, if applicable) **Date of Signature**

Personal Representative's relationship or legal ability to represent the patient_____

Printed Name/Address of Personal Representative _____

_____ _____

CCLSH Employee Date