Authorization for Release of PHI (Protected Health Information) Instructions

This form allows for your health information to be sent to another doctor, your employer, an insurance company, law office, etc. **Failure to fill out ALL parts of the form as described below will result in delays in your request, as it will have to be returned to you for completion.**

- **Patient Identification:** fill in all information
- **Authority to Release Protected Health Info:** write the name and CONTACT INFORMATION (phone, fax, address) for the person you would like your records to be sent
- **Information to be Released:** please check EITHER complete record or partial record (if you choose partial, please specify treatment dates and which parts of your records are to be sent)
- **Purpose for Disclosure:** please check one
- **Drug and/or Alcohol Abuse:** please check yes or no for BOTH questions
- **Expiration Date:** the authorization MUST have an expiration date. N/A IS NOT ACCEPTABLE. Please either choose a date (many people choose one year from today) or an event (end of litigation, action taken, etc.)
- **Signature:** please sign and date the bottom of this page
- **Submit Completed Document:** Once finished, return the completed form to the medical records department by coming to the clinic at any time during normal business hours. If it isn’t convenient for you to come to the clinic, you can print the request form and return it to the medical records department via mail, fax, or email.

Please note that **requests are processed in the order received.** While we strive to process requests in the quickest time frame possible, it may take up to fifteen (15) days before we are able to get to your request (pursuant to LA R.S. 40:1299.96.). If you have any questions or if we can be of any assistance, please do not hesitate to contact us!

Thank you,
Medical Records Department
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification
Printed Name: ___________________________ Date of Birth: ___________________________
Address: ____________________________________________________________________________
Social Security #: ___________________________ Telephone #: ____________________________

Authority to Release Protected Health Information I hereby authorize Bone and Joint Clinic of Baton Rouge, Inc. to release the information identified in the authorization from the medical records of the above named patient and provide such information to
Name: ____________________________________________________________________________
Address: ____________________________________________________________________________
Phone and/or Fax #: ____________________________________________________________________

Information to be Released (Choose one below)
☐ Complete Medical Record (including itemized billing) covering any and all periods of treatment from birth to the present date
☐ Partial Medical Record covering the periods of health care from ___________ to ___________
☐ History and Physical Exam
☐ Laboratory Test Results
☐ Photographs & Videotapes
☐ Diagnosis & Treatment Codes
☐ Consultation Reports
☐ X-ray Reports
☐ X-ray films/images
☐ Discharge Summary
☐ Progress Notes
☐ Complete Billing Record
☐ Other (specify)

Purpose for Disclosure I am authorizing the release of my Protected Health Information for the following purpose:
☐ at the request of the individual
☐ treatment with another doctor
☐ legal
☐ claim
☐ other (specify)

Expiration Date Unless revoked, this authorization will expire on the following date or after the following time period or event: __________________________

Drug /Alcohol Abuse, HIV/AIDS, Psychiatric Records Release
Yes ☐ No ☐ 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.

Yes ☐ No ☐ I also understand that 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.

Right to Revoke Authorization Except to the extent that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice to Bone and Joint Clinic of Baton Rouge, Inc. Attn: Medical Records Dept. 7301 Hennessy Blvd., Suite 200 Baton Rouge, LA 70808.

Re-disclosure I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative I understand that I do not have to sign this authorization, and my treatment of 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, 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 of copy the protected health information to be used or disclosed. I hereby release and discharge Bone and Joint Clinic of Baton Rouge, Inc., its employees, agents, and owners of any liability and the undersigned will hold them harmless for complying with this authorization.

Signature: __________________________________________________________________ Date: __________________________

Description of Relationship if not Patient: ____________________________________________________________________________