Authorization for Release of Protected Health Information

1. Patient Information

Patient Name_____ Date of Birth ___/___/___

Patient Address _____
Street City State Zip

Patient Home Phone_____ Patient Email_____

2. Recipient Authorization

I _____ hereby authorize_____ to release a copy of my medical records **to Alexandria Women's Center 3304 Masonic Dr. Ste 4001 Alexandria, LA 71301**

3. Information to be Released. Check all that apply and specify dates of service.

( ) Entire Medical Record _____ ( ) Lab Reports_____
( ) Visit Notes _____ ( ) X-Ray Reports_____
( ) Pathology Reports_____ ( ) Other (specify)_____
( ) Psychotherapy Notes _____(If so, this is the only item you may request on this authorization)

4. Purpose of Information Release

( ) Further medical care ( ) Disability Determination
( ) Payment of Insurance Claim ( ) Vocational rehab, evaluation
( ) Legal Investigation ( ) At the request of the individual
( ) Applying for Insurance ( ) Other (specify): _____

5. Inclusion of Privileged Information

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

6. Patient Rights and Privacy

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclose pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.
- **This authorization will automatically expire one year from the date signed.**

Signature of Patient: _____ **Date:** _____

Signature of Legal Representative: _____ **Date:** _____

Relationship to Patient: _____