ALEXANDRIA WOMEN'S CENTER
AUTHORIZATION FOR RELEASE OF PROTECTED 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

☐ 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.

4. 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_____

PRINT THIS FORM