ALEXANDRIA WOMEN'S CENTER

304 Masonic Dr - Suite 4001 - Alexandria, LA 71301
Phone: 318-443-7222 Fax: (318) 443-7641

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, ______________________________, do hereby authorize AWC; Dr. ______________________________ to release:
PATIENT'S NAME FACILITY NAME

PLEASE CHECK ONE

- ☐ All medical, insurance, and financial records pertaining to the care and treatment received at ____________________________
- ☐ Specific records only:____________________________
- ☐ Information pertaining to the following dates of treatment____________________________

PLEASE CHECK ONE

☐ I do ☐ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PATIENT'S NAME:____________________/______________________/________ DATE OF BIRTH:__________________________

ADDRESS:____ SS#____

CITY:________________________________ STATE:__________________________________ ZIP:________________________

PHONE NUMBER:____

INFORMATION TO BE RELEASED TO:

NAME:____

ADDRESS:____

CITY:________________________________ STATE:__________________________________ ZIP:________________________

____ ____________________________

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE & RELATIONSHIP **DATE**

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION **ATTACHMENT B**

PATIENT IDENTIFICATION

NAME:____________________/______________________/_______ DATE OF BIRTH:__________________________

ADDRESS:____

CITY:_________________________________ STATE:__________________________________ ZIP:________________________

SOCIAL SECURITY #____________________________________ PHONE NUMBER:____________________________________

AUTHORITY TO RELEASE PROTECTED INFORMATION

I hereby authorize ____ to release the information identified in

this authorization form from the medical records of ____ and provide such

information to ____.

INFORMATION TO BE RELEASED

From (date) ____ to (date) ____

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films/images
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill

☐ Other, specify

____

PURPOSE OF THE REQUESTED DISCLOSURE OF PROTECTED HEALTH INFORMATION

I am authorizing the release of my Protected Health Information for the following purposes
(e.g. a purpose may be "at the request of the individual"):

____

____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE

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.

CHECK ONE: ☐ Yes ☐ No

I understand 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.

CHECK ONE: ☐ Yes ☐ No