



Patient Authorization for Use/Release of Information
All Fields Must Be Completed For Processing

Patient Name: _____ Date of Birth: _____
 Address: _____ Last 4 Digits of SSN: _____
 City: _____ State: _____ Zip: _____

PROVIDER AUTHORIZED TO RELEASE THE PHI	ENTITY RECEIVING THE PHI
I hereby authorize St. Charles Surgical Hospital or _____ <input type="checkbox"/> to release <input type="checkbox"/> to request medical information (protected health information) to/from the entity listed	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

MEDICAL RECORD TO BE RELEASED	Dates of Treatment to be Released: _____ to _____ Or Specify a Date: _____ Check off items being released: <input type="checkbox"/> Courtesy Abstract - Labs, Op Report, Radiology Reports, H&P, Pathology Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Anesthesia Record <input type="checkbox"/> Pathology Report <input type="checkbox"/> Labs <input type="checkbox"/> History and Physical <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Entire Record (Applicable Fees will be applied) <input type="checkbox"/> Other _____
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The patient's authorization is required to release certain types of records, including HIV test results, alcohol and/or drug abuse treatment and information, psychiatric treatment, and genetic testing (defined in the Genetic Information Non-Discrimination Act of 2008 – GINA, Section 2017 A and B. By placing an "X" in the following box(es), I am indicating that I DO NOT authorize the release of HIV test results, alcohol and / or drug abuse treatment, and genetic testing.

I DO NOT authorize the release of: HIV test results Alcohol/Drug abuse treatment/information Psychiatric treatment Genetic testing

PURPOSE OF RELEASE	<input type="checkbox"/> Personal <input type="checkbox"/> Continuing Treatment <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Other _____
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REQUIRED STATEMENTS (Patient's / Requestor's Understanding)	<ul style="list-style-type: none"> ■ I understand that I have a right to revoke this authorization at any time. I understand that If I revoke this authorization, I must do so in writing and present written revocation to St. Charles Surgical Hospital, Health Information Management Department; 1717 St. Charles Avenue, New Orleans, LA 70130. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company for services already rendered. ■ The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. ■ Fee / charges will comply with all laws and regulations applicable to release of information. ■ I understand authorizing the use of disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.
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EXPIRATION	This authorization shall expire upon the expiration Date or Event: _____
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If I fail to specify an expiration date, this authorization will expire 1 year from the date on which it was signed.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Legal Representative	Relationship to Patient	Date
Signature of Witness (If patient is unable to sign)	Relationship to Patient/Credentials	Date