

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name	Birthdate	Social Security No. <i>(optional)</i>
Address		
City	State	Zip Code

INFORMATION TO BE RELEASED TO (Requestor)			Facility (Covered Entity Provider) authorized to release PHI		
Name			Name		
Address			Address Red Stick Pediatrics		
City State Zip			City 888 Tara Blvd. Baton Rouge, LA 70806		

This authorization shall expire on the following date or event: _____ . If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.

Purpose of disclosure:

- Medical Care
 Legal
 Insurance
 Personal
 Other _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED Starting _____ Ending _____

	Starting Date	Ending Date		Starting Date	Ending Date
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<input type="checkbox"/> All PHI in the medical records			<input type="checkbox"/> Consultation Reports		
<input type="checkbox"/> History and Physical Reports			<input type="checkbox"/> Discharge Summary		
<input type="checkbox"/> Progress Notes			<input type="checkbox"/> Itemized Billing Statement		
<input type="checkbox"/> X-Ray Tests/Reports			<input type="checkbox"/> Patient Information Form		
<input type="checkbox"/> Laboratory Reports			<input type="checkbox"/> Other Specified:		

The Protected Health Information listed below WILL BE released when included in the above medical information unless specifically indicated otherwise.

Psychiatric/Mental Information	AIDS/HIV/Genetic Information
Alcohol/Drug/Substance Abuse Information	OTHER _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorized the disclosure of the protected health information as stated:	
(1) Patient Signature _____	Date: _____
(1) PATIENT REPRESENTATIVE SIGNATURE (IF APPLICABLE)	(2) RELATIONSHIP TO PATIENT
	Date: _____