



P.O. BOX 2668 • HAMMOND, LA 70404
(985) 345-2700

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to disclose
health information from the health records of:

Name: _____ DOB: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (____) _____ MR#: _____

Release to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Covering the period(s) of health care: From: _____ To: _____

Description of information that may be disclosed under this authorization:

- | | | | |
|-------|--------------------|-------|---------------------|
| _____ | Face Sheet | _____ | Path Report |
| _____ | Discharge Summary | _____ | Physician Orders |
| _____ | History & Physical | _____ | Progress Notes |
| _____ | Consults | _____ | Emergency Record |
| _____ | Lab | _____ | Respiratory Therapy |
| _____ | X-ray | _____ | EKG Tracings |
| _____ | Outpatient Record | _____ | Nurse's Notes |
| _____ | EKG | _____ | EEG |
| _____ | Operative Report | _____ | Other: _____ |

I understand that I have the right to refuse to disclose any/all the conditions listed below; therefore, I DO NOT AUTHORIZE release of the checked conditions:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)
- Psychiatric Care
- Treatment for Alcohol and/or Drug Abuse
- Communicable Disease

The information will be disclosed for the following purposes:

- At the request of the individual (sufficient when the authorization is initiated by the individual)
 - Transfer of patient to another facility/provider for continuum of care
 - Other as stated below:
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I understand that health information released as a result of this authorization may be re-disclosed or shared by the person or entity receiving the information and may not be protected by federal/state regulations.

I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment unless a third party requests the service and/or release of information. (For example, if you present for a drug test solely for the purpose of having the results disclosed to your employer, North Oaks may refuse to perform the drug test if you refuse to sign this form.)

I understand that I may revoke this authorization in writing at any time. Revocation will be effective when received by North Oaks Health System. I further understand that any information already authorized and released is not covered by this revocation.

This authorization expires one year after the date affixed below. This authorization will expire upon fulfillment of this request without my express revocation.

Signature of Patient or Representative

____/____/_____
Date

Patient's Name

Name of Personal Representative (if applicable)

Relationship to Patient (Authority)

Reason Patient Cannot Sign

Signature of Witness

(A copy of this signed form must be provided to the patient.)