NorthOaks Health System
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_____

Telephone #(_____)_____ Fax #(_____) _____

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:_____

FOR STAFF USE ONLY:

Images printed/CD burned by: _____ Date: ____/____/____

I understand that I have the right to refuse to disclose the results for the condition listed below. Therefore, I DO NOT AUTHORIZE release of the checked results:

❑ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

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:

_____

_____

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 dis¬closed 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.)