



Health Information Management
Release of Information Desk: (985) 230-6530
Fax: (985) 230-6479
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 healthcare 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 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. 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.)