

Authorization to Release or Obtain Protected Health Information (PHI)

1 I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

<input type="text"/> Patient Last Name	<input type="text"/> Patient First Name	<input type="text"/> Date of Birth (MM/DD/YYYY)	
<input type="text"/> E-mail Address	<input type="text"/> LSU ID#	<input type="text"/> Phone Number	
<input type="text"/> Street Address	<input type="text"/> City	<input type="text"/> State	<input type="text"/> Zip

2 This Authorization allows the Student Health Center to: (check one or both)

- RELEASE** copies of your record to (or discuss your information with) the provider/person/facility below
- OBTAIN** copies of your record from (or discuss your information with) the provider/person/facility below

<input type="text"/> Name of Provider/Person/Facility	<input type="text"/> Address
<input type="text"/> City, State, Zip Code	<input type="text"/> Phone # / Fax # (include area code)

- Mail Records Fax Records E-Mail CD/Storage Device Pick Up Discuss Verbally

INFORMATION MAY ONLY BE SENT THROUGH A SECURE EMAIL ACCOUNT (EX: @LSU.EDU). NO PERSONAL EMAIL WILL BE ACCEPTED (EX: @YAHOO.COM).

3 INFORMATION TO BE RELEASED *Covering the periods of care from:* to
MM/DD/YYYY MM/DD/YYYY

<p>HEALTH INFORMATION</p> <p><input type="checkbox"/> Chart Note(s) <input type="checkbox"/> Pharmacy Records</p> <p><input type="checkbox"/> Laboratory Results <input type="checkbox"/> Itemized Billing Statement(s)</p> <p><input type="checkbox"/> X-Ray Report/CD <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Immunization Records</p>	<p>MENTAL HEALTH INFO. CONTENT</p> <p><input type="checkbox"/> Treatment Summary _____</p> <p><input type="checkbox"/> Diagnosis _____</p> <p><input type="checkbox"/> Psychiatric Summary _____</p> <p><input type="checkbox"/> Other _____</p>
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4 PURPOSE OF DISCLOSURE: Health Care Legal Insurance Personal Other _____

5 SENSITIVE INFORMATION RECORDS RELEASE *The following info. will be released when included in the health or billing record unless you indicate otherwise:*

- Do not release AIDS/HIV or any STD test results Do not release any records of psychiatric care or mental health information
- Do not release any records of alcohol/drug/substance abuse Do not release any records of genetic testing

6 EXPIRATION DATE *Unless revoked, or otherwise specified, this authorization will expire one year from the date of signature:* _____

7 I UNDERSTAND THE FOLLOWING:

- Except to the extent that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice to the Privacy Officer, LSU Student Health Center, 16 Infirmary Lane, Baton Rouge LA 70803.
- The information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.
- I may refuse to sign this authorization and that it is strictly voluntary. Louisiana law requires a written authorization in order to release Protected Health Information (PHI) to a third party.
- My right to healthcare treatment and the payment for my healthcare is not conditioned on this authorization, unless disclosure or use of the information is necessary for treatment.
- I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

8 I UNDERSTAND AND AUTHORIZE THIS RELEASE

Print Name of Patient or Legal Representative _____ **Date** _____

Signature of Patient or Legal Representative _____ **Relationship to Patient** _____