Name:
DOB:
Chart:
Age:
Date:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ DOB _____
Address _____ SSN _____
City _____ State _____ Zip _____

PROVIDER AUTHORIZED TO RELEASE THE PHI:
Name _____
Address _____
City _____ State _____ Zip _____
Attention: _____

ENTITY RECEIVING THE PHI:
Orthopaedic & Sports Clinic
1014 W. St. Clare Blvd. 1020
Gonzales, LA 70737
Attention: _____

This Authorization will expire on the following date or event:

Date: _____ Event _____
Purpose of this Disclosure: Medical Care

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
○ All PHI in record		
○ Progress notes		
○ Laboratory tests		
○ X-Ray Test/ Reports		
○ History & Physical Exam		
○ Discharge Summary		
○ Consultation Reports		
○ Itemized Billing Statement		
○ Other		

The following information will be released when included in the above information unless you indicate otherwise:

☐ AIDS or HIV test results
☐ Alcohol, drug or substance abuse treatment
☐ Psychiatric or mental care treatment
☐ Other (specify)

I understand that:

1) My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
2) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3) Fees/ charges will comply with all laws and regulations applicable to release of information.
4) If a 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 disclosed.
5) A copy of this authorization shall be sufficient as if an original.
6) I have the right to receive a copy of this form after I sign it.

I agree that Orthopaedic & Sports Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary)	Date:
Personal Representative's Relationship to Patient:	