CLINIC SITE: ZACHARY • FAX TO: 225-658-1249

PHONE: 225-306-2000 • **TOLL FREE:** 888-414-7247 • **WEBSITE:** www.shchc.org

Authorization to Release or Obtain Protected Health Information (PHI)

***HEALTH INFORMATION MAY ONLY BE TRANSMITTED ELECTRONICALLY AS A SECURE MESSAGE THROUGH THE PATIENT PORTAL OR VIA SECURE FAX.**

Provider Requesting Notes: ______________________________

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

   Patient First and Last Name:______________________ Patient Chart # ______________

   Patient Date of Birth:____________ Last 4 digits of SSN__________ Phone #:______________

2. This Authorization allows Southeast Community Health Center to:

   ☐ RELEASE copies of your record to (or discuss your information with) the provider/person/facility below

   AND/OR

   ☐ OBTAIN copies of your record from (or discuss your information with) the provider/person/facility below

   ______________________________ ______________________________
   Name of Provider/Person/Facility Street Address

   ______________________________ ______________________________
   City, State, Zip Code Phone #/ Fax # (include area code)

3. **INFORMATION TO BE RELEASED** *Covering the periods of care from:* ______ *to* ______ MM/DD/YYYY *to* MM/DD/YYYY
   Check all that apply:

HEALTH INFORMATION		MENTAL HEALTH INFORMATION
__Entire Record	__Immunization Records	__ Psychiatric Summary
__Medical History	__Pharmacy Records	__ Diagnosis
__Telemedicine	__Itemized Billing Statement(s)	__ Laboratory Results
__Chart Note(s)	__Telebehavioral Services	
__Other______________________		__Other______________

4. **PURPOSE OF DISCLOSURE (circle):** 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 **(Check all that apply)**:

   __ ***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 (Applicable under Federal Law 42 CFR PART 2):**
   - 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, Southeast Community Health Systems, 6351 Main Street, Zachary, LA 70791.
   - 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______________________________ Date____________

Revised: 8/04/2021 **ALL SECTIONS ARE REQUIRED. MUST PROVIDE PHOTO ID PRIOR TO RELEASE OF INFORMATION.**