PRIORITY HEALTH CARE©
A UNIVERSAL APPROACH TO CARE

AUTHORIZATION to RELEASE or OBTAIN HEALTH INFORMATION

Request Date: _____

Patient Name: _____ **Date of Birth:** _____

Mailing Address (City, state, zip): _____

Social Security Number: _____ Phone Number: _____

I hereby authorize:

Name: _____ Phone Number: _____

Mailing Address (City, state, zip): _____

☐ **RELEASE Information TO or ☐ OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released AND/OR requested.)

Name: _____ Phone Number: _____

Mailing Address (City, state, zip): _____

The **Purpose of this Authorization** is indicated in the box(es) below**.** *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Changing Primary Care Providers ☐ Personal

☐ Research related treatment ☐ Legal Investigation or Action

☐ Creating health information for disclosure to a third party

☐ Other (specify): _____

I authorized the indicated health information to be released and/or obtained. *(Place an "X" in the box(es) by authorized information.)*

☐ Complete Billing Record ☐ Complete Health Record ☐ Consult Reports ☐ History and Physical (H&P)

☐ Laboratory Results ☐ Medications ☐ Treatment Plans

☐ Other (specify): _____

In compliance with state and/or federal laws which require special permission to release privileged information, please release the following indicated records. *(Place an "X" in the box(es) by authorized information.)*

☐ Alcohol/Drug Treatment ☐ Hepatitis B or C testing ☐ HIV/AIDS ☐ Psychotherapy Notes

☐ Psychiatric Evaluations ☐ Psychological Evaluations ☐ Sexually Transmitted Diseases (STD)

☐ Other (specify): _____

This authorization shall expire on _____ (date) and is needed for the period beginning _____ and ending _____.

**I understand that this authorization will expire one (1) year from the effective date on which it was signed unless otherwise specified above. **

Over →

I understand that my signature below indicates that an authorization to use, disclose, or obtain my health information is needed per my request or for services. I further understand that if I authorize a record to include drug/alcohol treatment, HIV/AIDS, or Hepatitis B/C related conditions that information shall be protected under local and federal regulations and cannot be further released without my written consent unless otherwise provided in (42 CFR Part 2) or other restricting laws. Once information is disclosed according to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from re-disclosure of the information. However, when disclosing mental health, intellectual and developmental disabilities information protected by state law (La. Admin Code. tit. 48, pt. I, § 503) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that re-disclosure is prohibited except as permitted or required by these two laws.

I understand that:

- If I do not sign this authorization, my health care, and payment for my health care will not be affected.
- I have the right to revoke this authorization at any time by submitting a written request to the Privacy Officer (PO) or appointed designee, except where disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical provider covered by the privacy rules and regulations, the information stated above can be re-disclosed.
- If the authorized contains alcohol/drug treatment information Federal Confidentiality protects the disclosure Rules (42 CFR Part 2), it may not be re-disclosed without my written consent unless otherwise provided for in the regulations.
- If my request for information is not sent to another health care provider, Priority Health Care (PHC) reserves the right to charge a reasonable fee to obtain copies of my medical records.
- My health information may be released in an electronic, faxed, or copy format.

I acknowledge that I have read the **front and back** of this form before signing.

_____ _____

Signature of Patient/Legal Representative Date

Relationship to patient (if not patient) ☐ Parent ☐ Legal Guardian ☐ Other _____

Patient or representative has been provided a copy of this authorization _____

Staff's signature providing copy